		í	For State Registrar	State of M	laryland		artment tificate			ind Mei		iene)5	19502
	0		1. Decedent's Name (First, Middle,	Last)						2.	Date of Dea	th		3. Time of Death
	Physicia /Medic		WILLETTE	1	PETTY						Month MAY	Day 19,20	Year 10.5	1:40 A M
	Examin		4a. Facility Name (If not institution,				4b. City, To	own, or L	ocation of			4c. County		
			SHADY GROVE	ADVENTIST	HOSE	ITAL	RO	CKV:	ILLE			TOM	GOM	IERY
	Funeral		5. Social Security Number	6. Sex 7. A		ast birthday)	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birth	oplace (State or Foreign
	Director		235-72-1916	1 M 283F	75	Yrs.	Nontino	Juyu	110010	N	ov.11			Carolina
	pue *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	sho	5	,	gomery	100.0.0	Germa		'n						1 ☐¥Yes 2 ☐ No
	28a-f	ect	10e. Street and Number	90	1		10f. Zip (10g. Citizen of V	What Car	
	a or	늅		m 71	a 1		101. Zip C		874			U.S.		untry?
	eath	eral	22 Martins	12. Was Decedent			Was Decede			nin? (Specif	y Yes or No-			rican Indian,
	ter d	In In	1 Never Married 2 Marrie	Armed Forces	?				, Mexican,	, Puerto Ric	y Yes or No- an, etc.)	Blac	k, White	
8	urs a	þ	3€ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1.0		1□Yes 2	No	Specify:			Specify	· Bl	ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "deal Eventher mout by notified at	ted	15. Decedent	s Education		16a. Dece	ient's Usual	Occupat	ion	-6		16b. Kind of Bu	ısiness/l	Industry
21	e. en "r Mad	ed ((Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work DO NOT use	retired)	nng most	or working				
2	or th	Son	8th]	Domes	tic				Home	:	
2	d oth	Be (17. Father's Name (First, Middle, L	ast)								Maiden Sumam	e)	
ya	Ment Ment arke	ပ္		ithers						Susi		yan		
Maryland	2 sh and Is m		19a. Informant's Name/Relationsh	ip (Type, Print)								r, City or Town,		
2	and lealth m 27		Gloria Bryan	- Sister	COL B			_						'A 22205
9	A SE SE D		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	9 (ace of Dispo emetery, crer				Date		20c. Location -		
Ë	tant:		`4 □Donation 5 □ Other (Sp		Met	ro F						Alexan		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If them 27 is marked other than "natural", or items 23a or 28a-1 show my injury or other traumatic event. It is Michael Examiner mantite to relifice at once.		21. Signature of Funeral Source L	icentee MOUA	In a									Ome, P.A. MD20350
			23a. Part1. Enter the disease, or shock, or hear failure. List	complications that cause	ed the death	. Do not ent	er the mode	of dying,	such as	cardiac or re	espiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	S	to.	' C	Sh		clc					Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequ	ience of):		,						119412
	Examiner		Sequentially list conditions	b. Mar	50	w	3 ~ 6	7	DCM	sca.	lplbr	· pfni	pds.	\
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	uence of):		,				7		
	ecute and -trans	cam	that initiated events resulting in death) Last	c. Due to (or a	1/6	>c	2 Dir	PV	fer.	7	791	1006		
8760,	cate be executed oblysician and the burial-transit		roduling in doutin, Eddi	Due to (or a:			Pa		1	1. 1	ca			
87	physicate I	dica		o. Era	Sto	126	16	na	1	2) (2	ca	16		
9 x	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome	e of program	nou				-				
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal	death 3	Ectopic pre						te of delin nth	very Day Year
P.0.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown	at time of de	atn 5L	Other (spe	спу)						
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditio	ns contributing to death	but not resu	ulting in the u	nderlying ca	use giver	n in Part I.		23e. Did to	bacco use cont	ribute to	the cause of death?
ds,	w requires that s been signed t should be det	d by	Diabe	_	1115			•			1 🗆 Y	es 2 No	3 🗆 Pro	obably 4 Unknown
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a	(0		05.11								1 Tes	21 No 1	Yes	200-110
Division of Vital Records,	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Other			Check only o			
of	Phys rthis ral dii	To :	1 Yes 27 No 27. Manner of Death	28a. Date of In		ER/Outpatier 28b. Time o		4	4 🔲 1901			ence 6 Oth		cify)
on	ding P.h.	tion	Natural 5 Pending	(Month, D	ay Year)	Injury	м	c. Injury Work	es 2 🗆 N			,.,		
İSİ	I or Attending after death. Director: After I in by the fune	ertification;	3 ☐ Suicide 6 ☐ Could r	ot be	njury - At ho	me, farm, sti	eet, factory,				. Location (S	treet and Numb	er or Ru	ral Route Number,
Ö	after after Dire	erti	4 Homicide	building, 6	etc."(Specify	1)					City or Tow	n, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)	g Physician: To the bes Examiner: On the basis and manners	of examinat	tion and/or in	vestigation,	in my opi	nion, deat	th occurred	at the time, o	date and place,	and due	to the cause(s)
	ro the vithin o the omple	Med	29b. Signature and title of certifier	11 0			29c.	License	number			29d. Date signer	d (Month	n, Day, Year)
	7.		1 l'inus	315			1	16.	((1)	N-	2 ,	Ma.	10	2005
7		1 8	30. Name and a ress of person	who completed cause of	death (Item	23a) (Type	Print)	1	1162	- 11	וע	1119	11	(500)
			N. Congi	19520	Des	teri	Dui	7	Go	ern.	onto	un 1	12	20876
	Sta	ate	31. Date filed (Month, Day, Year)	32/Regis	trar's Signa	ture /	ack s			, , ,	r1 11 6	- 1)	- Inner	
	Registi		MAY 25	2005	w L	1- 140								n, Day, Year) 2005 20874

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY **Physician** 2005 RAGLAND 10:28 A **EVELYN** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3724 Swann Road Suitland Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Director 578-30-7104 Washington, DC 79 January 4 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits ehow in then "neturel", or items 23a or 28a-f ehov The Medical Examinar must be notified at 1X Yes 2 □ No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1666 Kramer Street N.E. 20002 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 📆 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked Irene William Chester Joseph Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health : 1666 Kramer Street N.E. Washington DC 20002 Floyd Ragland Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment o Importent: If any injury or * 4 ☐ Donation _ 5 ☐ Other (Specify) Harmony Cemetery 5/27/05 Landover, Maryland 21. Sign fun of Fundral Sovice License 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Park Enter-the disease, or complications that cause, the death. Do not enter the mod of dying, such as cardiac or respiratory rrest, shock, or near failure. List only one cause on each in Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Filipsicial /Medical Due to (outs a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as younsequence of): burial-transit Due to (or as a consequence of): HONH 400 (2500 15) physician Physician/Medical as the b IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 2 No 2 1 🗌 Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Accident 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ithin 24 hours e To the Funeral D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened at the time, date and place, and due to the cause(s) Medicel Examiner: Out the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29d. Date signed (Month Day, Year) 29b. Signature and fitte 29c. License number 30. Name and address of person ocompleted ca death (Item 23a) (Type, Print) 1647 Benning Edwin Chapman M.D. Rd Suite 200 Washington DC 20002 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2005 Registrar

PAUL LEROY REESE Medical Examiner REEDERS MEMORIAL HOME S. Social Security Name (If not institution, give street and number) REEDERS MEMORIAL HOME S. Social Security Name (If not institution, give street and number) REEDERS MEMORIAL HOME S. Social Security Number 215-36-6974 Usuel Residence of Decedent Usuel Residence of Decedent 100. State 100. County MARYLAND WASHINGTON BOONSBORO 101. Size and Number 101. Zip Code 101. Zip Code 102. Citizen of What Country? 102. Citizen of What Country? 103. Was Decedent Security (Specify Yes or No- 11 Martial Status 11 Martial Status 11 Martial Status 12 Was Decedent Security 13 Was Decedent Security 14 SOUTH MAIN STREET 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 16 Decedent's Sum of What Country? 17 Father's Name (First, Middle, Last) ALBERT WESLEY REESE MARY ELIZABETH SPESSARD MARY ELIZABETH SPESSARD MARY ELIZABETH SPESSARD MARY ELIZABETH SPESSARD 17 Father's Name (First, Middle, Last) ALBERT WESLEY REESE MARY ELIZABETH SPESSARD 18 Mother's Name (First, Middle, Maiden Summane) MARYLAND 19 Mailing Address (Street and Number or Paral Routs Number, City or Town, State Zip Code) 18 Mary ELIZABETH SPESSARD MARY ELIZABETH SPESSARD 19 Mailing Address (Street and Number or Paral Routs Number, City or Town, State Zip Code) 18 Mother's Name (First, Middle, Last) 19 Mailing Address (Street and Number or Paral Routs Number, City or Town, State Zip Code) 20 Decedent State S			1 - For State Registrar		Ce	rtificate of	Death		eg. No.	
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141 SOUTH MAIN STREET 21713 U.S.A. American Indian. U.S.A. Ame	ad at	ō	10a. State 10b. County		0c. City, Town or L		ON CONCORD			10d. Inside City Limits
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18. Dependence Equation 18. Dependence 18. Dependen	ardoer m	y Funer	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give	er in U.S. 13.			ecify Yes or No- Rican, etc.)	14. Race - Amer Bleck, White	ncan Indian, e, etc.
19. Michae's Name (First, Modile, Last) 18. Michae's Name (First, Modile, Marger) 18. Michae's Name (Fir	dica: E	eted b	15. Decedent's E	ducation	(Give	kind of work done	during most of work	rina		
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19a. Informants Name-Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cay or Town, State, Zip Code)		Be						•	,	
1 Reguest Commation 3 Permoval from State Commatory, orantary, ora		-			19b. Mail	ing Address (Street				ip Code)
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Interval advisor or learn trainule. List only one cause on agri mine. Immediate Cause (Final mediate Cause) (Final support of the control of the cause of the cau			1 X Buriet 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specification 1) 21. Signature of Fureral Sarvice Licen	Paul M.	CEDAR LAI Dean Br	MALORY OF Other place NN MEM. P. 2. Name and Addres AST FUNER	ARK O6/C So of Facility AL HOME	1/2005 7606 016 Boonsbor	HAGERSTOWN l national	MARYLANI Pike
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FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Day Year 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Unknow	the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. General	continuence of):					
24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1			23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 [4 ☐ Pregnant at tirr	Fetal death 3					,
25. Was case referred to medical examiner? 1	š	by	Part II. Other significant conditions of	contributing to death but r	not resulting in the t	inderlying cause give	en in Part I.			
2 2 No Nursing Home S Residence S Other (Specify)	page 2							autops	ned? death?	
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and late of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ō ā	္	examiner? 1 ☐ Yes 2 ② No	1 L Inpatient		nt 3 DOA	er: 4 Nursing Ho	me 5 Reside	ence 6 Other (Speci	ify)
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Certifier (Check only one) 29d. Date signed (Month, Day, Year)	by the rune	Iffication	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	(Month, Day Y	ear) Injury - At home, farm, st	M 1 ((?	28f. Location (St.	reet and Number or Rur	al Route Number,
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	Examiner	4e Fecility Neme (If not institution, giv				4b. City, Town, or L		4c. County	of Death	
		Julia Manor Hea			Mills doe d Voor	Hagersto			ngton C	
	Funeral Director	126-44-0321	7. Age (/	n yrs. lest birthdey) 79 Yrs.	If Under 1 Year Months Deys	Hours Min.	8. Date of Birth (Month, Day, Oct 1	_{Уеег)} 1925	9. Birthplace (Country) Cuba	State or Foreign
	Pu &	Usuel Residence of Decedent 10a. State 10b. County	10	0c. City, Town or Loc	ation				10d. In	side City Limits
	Meryl fehr	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		II- co	tor m				1[□Yes 2X No
	rec	Maryland Washing	JEOH	Hagers	10f. Zip Code		10	0g. Citizen of \	What Country?	
	h with	11341 Youngsto	oun Drive		21	742	ŀ	United	l States	
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21215-0020	ithin 72 ho he. han "natur Medical mpleted	15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12)	ducetion de completed) College (1-4or 5+)	16e. Decede (Give k life. D		petion during most of world)	king		usiness/Industry	
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and	2 should be filed end Mentel Hygis le marked other aurmatic event, I						a Vilları		10)	
2	should and Men marke umartic	Ramon Garcia 19a Informant's Name/Relationship (Tune Print)	19h Mailing	Address (Street	and Number or Ru			State Zin Code	.)
<u>≅</u>	end 2 seelth er n 27 le	Carlos M. Ruano	**			stoun Dr.				
ē,	s 1 end f Heelth ftem 27 other tr	20a. Method of Disposition		20b Place of Dispos					City or Town, S	
Baltimore, Maryland	8 = 5	1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specific		Smithsbu			5-26-05	Smiths	burg Ma	ryland
att	mit. Perpertual portant:	21. Signature of Funeral Service Licer	<u> </u>		Name and Addre	4	ouglas A			
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	Physician /Medical Examiner	23a. Per 1. Enter the diseese, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	e to (or as e consequ	Car		or respiratory arre	est,	Inten	oximate val Between st and Death
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Box 687	net the deeth certificate be do by the ettending physicic leteched for use as the burnsteller. Physician/Medical	that initiated events resulting in death) Last	d	e to (or as e consequ	ence of):				1	
	the e	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the un	derlying cause giv	en in Part i.	23b. Did to	bacco use co	ntribute to the c	ause of death?
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of Vital Records,	The lew requires that the deeth certiste has been signed by the ettendin page 2 should be deteched for use Completed by Physician/N						24a. Was ar perform	n autopsy ned?	24b. Were eu available completi of deeth	prior to on of cause
æ							1 □ Ye	s 2000	1 ☐ Yes	2 No
/ita	certificate rector, peg	25. Was cese referred to medical examiner?					th (Check only one	θ)		
$\frac{1}{2}$	Z G Z	1 Yes 2 10	Hospital: 1 ☐ Inpatient	2 ER/Outpetient		4 Nursing H	ome 5 Reside			
Division o	To the Mospital or Attending Pheminin 24 hours effer deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification;	27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not by				y et k? Yes 2 □ No	28d. Describe ho			to Aliza bas
Div	Hospital or Al 24 hours efter of Funeral Direction by tely filled in by	4 Homicide determined	building, etc. (5			and date and alone	28f. Location (Sti City or Town	, Stete)		6 740111067,
	ne Hosp in 24 hou he Fune pletely fil edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicat Exam	ysician: To the best of m niner: On the basis of ex- end manner stated	emination end/or inve	estigation, in my o	pinion, death occur	red at the time, da	ate end place,	and due to the c	ause(s)
	within 2 vithe comple	29b. Signature end title of certifier			29c. Licens			9d. Date signe	d (Month, Day,)	(ear)
) Au	my	(h)		06033) 6	051	25/0	15
6H-	-5	30. Name end eddress of person who was a second sec	Completed cause of death	n (Item 23e) (Type, P	rint) (1)	b opa	\ <0u	40	Hagers	1000
	State	31. Date filed (Month, Day Year)	005 32. Registrer's	Signeture						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** р м Alexander M. Reher 2005 May 24. 3:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Rehab. & Nursing Center Burtonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days 1 X M 2 □ F 85^{Yrs.} March 29, Director 579-09-4716 1920 Florida Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show traumetic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Montgomery Maryland Silver Spring the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20901 303 Plymouth Street items 23a by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter Yes 2 No f Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: SpecifyWhite WWII 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Painter Truck Leasing 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Alexander T. Reher Elizabeth G. McDonald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 ts n any injury or other traunonce. Mary R. Reher/ Wife 303 Plymouth Street, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 31 20c. Location - City or Town, State May 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery * 4 □ Donation 5 □ Other (Specify) 2005 Washington, 21. Signature V Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760. Physician/Medical the 35 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Hinknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Diabetes Mellitus Type II, Peripheral Vascular Disease pe 1 Tes 2 No 3 Probably ★□Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Coronary Artery Disease page 2 autopsy performed 2 🔀 No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 X Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) in by determined 4 Homicide pelli 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the and manner stated To the 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifies D52261 May 24, 2005 0 +1 30. Name and address of person who completed crust of death (Item 23a) (Type, Print) Silver Spring, MD 20906 1517 Hugo Circle, Alan R. Segal, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 26 2005

JET 05-03617 Shir.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier		_	
Cartificate of Death	Grand	-	

ley Ruarl	ζ	1 - For State Registrar		State of Ma	aryland				lealth and i <i>Death</i>	Mental H	ygien Reg. N)5	19507
Physici /Medi		1. Decedent's Name (First, M Shirle	у А	nn Ruar	k					2. Date of D Month May	Da	2005	Year	3. Time of Death 1:56 A
Examir	ier	4a. Facility Name (If not institu			_		4b. City,	Town, o	Location of Deat			c. County		
		Dorchester G						brid	0				ester	
Funeral Director		5. Social Security Number 214-32-519 Usual Residence of Deceder	96	7. Ag □ M 2 □ X F	7 C	Yrs.	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of E (Month, I	Birth Day, Year B, 19	934		lace (State or Foreign try) yland
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Many e-f eh	ţō	MD Doi	rches	ster			Todd	vil	1e					1 ☐ Yes 2 ☐ No
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death with the Maryland ms 23a or 28e-f ehow rmust ke actiffied at		1909 Winga	ate I	Bishops 1	Head			2	1672		Uni	ted	Sta	tes
be filed within 72 hours after death with the Maryla nai Hygiene. ad other than "naturel", or items 23a or 28e-f ehov event, the Medical Exeminer must be mailtied at	by Funeral	11. Marital Status 1 □ N∰ever Married 2□ 3 Mg Widowed 4 □ Divo		12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		l i	Vas Deced Yes, spec	cify Cuba	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	10-		- America k, White, e	etc.
72 ho	eted	15. Dece (Specify only hi	edent's Ed	ucation		16a. Deced	ent's Usua	al Occup	ation during most of wor	deim m	16b. F	Cind of Bu	siness/Ind	lustry
vithin ne. hen *	Completed	Elementary/Secondary (0-		College (1-4or 5	+)	lite. L	OO NOT us	se retired)	Kiirig	Та	nnir	C	alon
filed v Hygie other t		12 17. Father's Name (First, Mid	ddla (ant)			Owne	r an	a M	anager		1			
should be find Mental Find Men	Be C			n Ronni					Nora M				9)	
2 should and Men is marke aumatic	မ	19a. Informant's Name/Relat	Alto		ng	19h Mailin	n Address	(Street :	and Number or Ru			-	O4-4 7	
th a		David A. Br							Ave., F					
Pages 1 ar nent of Hea int: If item: iry or other		20a. Method of Disposition 1 Burial 2 □ Cremat 4 □ Donation 5 □ Othe			Ce	ace of Dispos metery, crem L1 Cr	sition (Nan	ne of ther plac	e)	Date	20c. L	ocation - (City or Tov	
permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Sen	vice Licens	m. Cox	lo	22.	Name an	d Addres	s of Facility Fr ain St.	ampton . Fede	Fu:	nera	1 Hc	ome, P.A ID 21632
The law requires that the death certificate be executed Has been signed by the attending physician and sage 2 should be detached for use as the burial transit	edical Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. Due to (or as a b. Due to (or as a c. Due to (or as a d	10 S (ence of):	tie	. C	irdiov	aseu	lai	Die	2011	Interval Between Onset and Death
bt the death certific by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t 2	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 ☐ Fetal c	leath 3 □l	Ectopic pre Other (spe					23d. Date Mont	of deliver	y Day Year
w requires that been signed by should be deta	þ	Part II. Other significant con	ditions co	ntributing to death bu	t not result	ting in the un	derlying ca	luse give	n in Part I.		tobacco u			cause of death?
	Completed	<u> </u>								24a. Was auto perf 1 X Yes		pri	or to compath?	sy findings available pletion of cause of
Physicien; Th this certificate ral director, pag	Be	25. Was case referred to med examiner?	-	docortal:					26. Place of Deat	h (Check only		-	,	
Phys this ral dii	70	1X Yes 2 □ No 27. Manner of Death	1	lospital: 1 Inpatier		R/Outpatient	_		4 Nursing Ho					The same of the same of
n 0 0	Certification;	1 Natural 5 ☐ Per 2 ☐ Accident inv	nding estigation uld not be	28a. Date of Injun (Month, Day		8b. Time of Injury	М		es 2□No	28d. Describe				
he Hospitel or Attendin, in 24 hours after death. he Funerel Director; After pietely filled in by the fun		4 ☐ Homicide det	termined	28e. Place of Injubulding, etc.	(Specity)					28f. Location (City or To	wn, State)		
	Medical	one)	A /	sician: To the best of ner: On the basis of and manner stat	examinatio	edge, death on and/or inve	stigation,	in my op	inion, death occur	and due to the red at the time,	date and	place, an	d due to ti	he cause(s)
To with to con	<	29b. Signature and file of cer	Ar	XW	\			OCM			29d. Dat May	e signed ((Month, D.) 2005	
		5. K. HC	DGA	implehed cause of de				Penr	ı Street	Balti	nore,	, Mar	yland	1 21201
Stat Registra		31. Date filed (Month, Day, Ye	9ar) 1 200	32. Registra	's Signatur	-	2		-					
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death May Month Year **Physician** John William Reeves 2:10PM 23 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner La Plata Charles

| Hours | Charles | S. Date of Birth | 9. Birthplace (State of Greigh | 1927 | Washington | 1927 | Washington | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 | 1928 Charles County Nursing <u>Reha</u>b 7. Age (In yrs. last birthday)
77 Yrs. If Under 1 Year 5. Social Security Number **Funeral** Months Days 579-34-2818 1XM 2□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.
Important: if Item 27 is marked other than "natural," or items 23a or 28a-f show any Injury or other traumatic evant, the Medical Evariner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗖 No **Funeral Director** MD Charles Issue 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11470 Mohawk Court 20645 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? TYPES 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Govt. 17. Father's Name (First, Middle, Last)
Algernon Poole Reeves 18. Mother's Name (First Middle, Maiden Surname) Katherine Herron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela McCue/Daughter 420 West Garden Road, Oreland, PA 19075 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State MD Brinsfield-Echols Crem.5/25/05 Charlotte Hall, 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CHIRRHOSIS Examiner Physician/Medical Examiner pital or Attending Physicien: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician end filled in by the funeral director, page 2 should be detached for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ful as a consequence of. Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was en autopsy performed? 214NO 1 TYUE 1 Yes 2L'No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 27. Menner of Death 1 Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Sertifying Physicien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certiful D 44436 D 102 Paul Melon Ct Waldoff Md 20602 Name and address of

DHMH 16 Rev 6/95

State Registrar

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8760,			that initiated event resulting in death)	errying s Last	c. d.	Due to	(or as a	consequence	e of);									
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8		196	31. Date filed (Mor	MAY 2	5 20		Resistrar	's Signature	* /	Speed	U							

DHMH 17 Rev 1/2001

			For	State of Ma		partment of H		ental Hyg	iene	
		1	- State Registrar		Death		eg. No.	1-9-5-4-0		
	Physicia	in	Decedent's Name (First, Middle, Hallie	^{Last)} Isabell	Roberts	son		2. Date of Deat	31 0	3 Time of Death U
	/Medic Examin		a. Facility Name (If not institution,	give street and number)	ital	4b. City, Town, or	Location of Death	N	4c. County of De	ath
	Funeral		5. Social Security Number 215-16-4348	5. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 2,	1921 9. B	rthplace (Slate or Foreign Country)
	Director	-	Usual Residence of Decedent		10c. City, Town or	Location		1101 = 1		10d. Inside City Limits
	Marylar I show	tor	MD 10b. County Alleg	any	-	nberland				1 Yes 2 No
	vith the	Direc	10e. Street and Number 101 N. Cedar St	reet		10f. Zip Code	21502	1	0g. Citizen of What o	Country?
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39	filed within 72 hours after death with the Maryland Hygione. Hygiene. Hygiene maturel; or tlems 23s or 28s-f show ent, the Mayleal Examble must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 X Widowed 4 ☐ Divorced			1 □ Yes 2 No	Specify:		Specify: W	
15-0	n 72 hou "nature edical E	Completed	15. Decedent's (Specify only highest	grade completed)	(G.	cedent's Usual Occup ive kind of work done of b. DO NOT use retired	during most of worki	ng	16b. Kind of Busine	ss/Industry
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land	ild be file lental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, L Alonzo B. Hill	ast)			Katie M	cKinley	Hill	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other treumatic event, the Marical Examinar must be notified at once.		19a. Informant's Name/Relationsh Millard Robertso			ailing Address (Street 910 Old Jol		Route Number	r, City or Town, State erland N	e, Zip Code) MD 21502
ore,	es 1 an of Heal If item 2 or other	-	20a. Method of Disposition	3 □Removal from State	cemetery, o	sposition (Name of crematory or other place	ce)	Date 6/2/2005	20c. Location - City	
Baltimore,	nit. Pag antment ortant: injury c		* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	ecify)	Scarpelli F	Funeral Home 22. Name and Addre Scarpel			Cresapto	wn IVID
Ba	Den Gen yes		MAM	HONU	N	108 Viro	inia Avenue	: Cumberl	and, MD 215	Approximate
	Physician		23a. Part1. Enter the disease, or shock or heart failure. List of immediate Cause (Final	complications that caused only one cause on each lin	18.	enter the mode of dyl	ng, such as cardiac d	or respiratory arr	est,	Interval Between Onset and Death THREE DAYS
	/Medical Examiner		disease or condition resulting in death)	a	a consequence of):				_	/11/000 01110
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	в ои кырмагаа оту		_			
γ.	ate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	cate be e			d						
Box 6	leath certifica attending ph i for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 □Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
Ю. В	that the deat ned by the att detached for	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)				
<u>α</u>	6 6	by	Part II. Other significant condition	ns contributing to death b	ut not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did to	lame	e to the cause of death? Probably 4 Unknown
Records,	The law require cate has been sig page 2 should b	Completed						24a. Was autop perfor	sy prior death	autopsy findings available to completion of cause of
Vital		0	25. Was case referred to medical	1			26. Place of Deat			Yes 2™ No
of Vi	d is	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Minpatie		atient 3 DOA			ience 6 Other (5	Specify)
	Jing After fune	tlon:	27. Manner of Death 1 Manner of Death 1 Natural 5 □ Pendin 2 □ Accident investig		y Year) 28b. Tim Inju	ıry Wo	iry at ork?] Yes 2 □ No	28d. Describe i	low injury occurred	
Division	i or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	and 200. Flace of In	jury - At home, farm tc. <i>(Specify)</i>	, street, factory, office		28f. Location (S City or Tox	Street and Number o. vn, State)	r Rural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifyin (Check only 2 Madical one)	g Physician: To the best Examinar: On the basis o and manner st	of examination and/	death occurred at the tor investigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 3	Med	29b. Signature and title of certific	telon	n		se number 3417		29d. Date signed (M	
	Ŋ		30. Name and address of person JAMCJ R- MO	who completed cause of	death (Item 23a) (T)	ype, Print) VAL HIGHW	AY LAVAL	E MARI	TLAND 2	1502
		ate	31. Date filed (Month Day, Year)	9 2005 32 Regist	rar's Signature	Spell				
	-		1			Z				

		_1	For State Registrer	tate of Marylar		artment of H tificate of L			ene g. No. 2005	19511
Н	Physicia	an	. Decedent's Name (First, Middle, Last)	NII		E 8		2. Date of Death Month JUNE 3,	Day Yeer	3. Time of Death 7:25 A M
	/Medic Examin	al. er 4	ROBERT HERMAN SCHMII a. Facility Name (If not institution, give street 1965 MEMORIAL DRIVE			4b. City, Town, or OAKLAN			4c. County of Dea	th
	Funeral Director		213-36-8600	2□ F 7. Age (In yrs. 72	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bir C 1, 1932 M	thplace (State or Foreign ountry) ARYLAND
pool not be	oeath with the Maryland ims 23a or 28a-f show rmust be ratified at	irector	Journal Residence of Decedent 10a. State 10b. County MD GARRETT 10e. Street and Number	10c. C	OAKLA				0g. Citizen of What C USA	10d. Inside City Limits 1 □ Yes 2 1 No ountry?
	be filed within 72 hours after beath with the Marynal Hygione. do ther then "naturel", or liems 23a or 28a-f show event, the Mardical Examiner must be added at	<u>a</u>	1965 MEMORIAL DRIVE 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in the Amed Forces? 1X Yes 2 No If Yes, Give 55 - Year or Dates:				(Specify Yes or No- orto Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
Maryland 21215-0036	filed within 72 hou Hygiene. other then "nature ent, the Medical E	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of w f)	vorking	16b. Kind of Business	
lang 2	uld be tiled fental Hygi rked other tic event,	o l	17. Father's Name (First, Middle, Last) HERMAN OTTO SCHMIDT				MARIE		DING	
, Mary	and 2 should be nath and Menta 7.27 Is marked er treumetic ev		19a. Informant's Name/Relationship (Type, ISABELLA SCHMIDT - I	WIFE	1965	MEMORIA		OAKLA	ND, MD 215	550
Baltimore,	permit. Pages 1 and 2 should be Department of Heatls and Menta Important: If item 27 is marked eny injury or other treumetic evonce.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Rem 1 ☒ Donation 5 ☐ Other (Specify)	State	RRETT 1	osition (Name of or other place) MEMORIAL (GARDS 6/	7/05	OAKLAND,	
Balt	permit. Depart Import eny inj		21. Signature of Funeral Softyice Ligensee ### August 15 Funeral Softyice Ligensee #################################	MOO	167 I		ERAL HOM	1E - OAKLA	BOX 243 ND, MD 21:	Approximate
	Pnysician /Medical		shock, or heart failure. List only one Immediate Cause (Final	Diabetes Due to (or as a conse	melli					Interval Between Onset and Death
,160,	icate be executed xm in the purial-transit to the burial-transit t	Ical Examiner	if any, leading to immediate	chronic r Due to (or as a conse	equence of): Leroti		ovascu	lar dise	ase	yrs
.O. Box 68	death certif e attending id for use at	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o Month	delivery Day Year
О.	es tha gned be de	by	Part II. Other significant conditions control	ibuting to death but not r	resulting in the	underlying cause gi	ven in Part I.			to the cause of death? Probably 4 Unknown
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ion of Vital	ding Physician: n. After this certific funeral director,	To Be	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	espital: 1 □ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time	of 28c. Inju	her: 4 🗆 Nursin	28d, Describe h	dence 6 □Other (S _i now injury occurred	
Division	tal or Attending rs after death. el Director: Afte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. <i>(Sp</i> e	ecify)			City or Tov	vn, State)	Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Exemination)	er: On the best of my and manner stated.	knowledge, de nination and/or	investigation, in my	time, date and pl opinion, death o	occurred at the time,	date and place, and d	
,,	To the within To the comple	2	29b. Signature and title of certifier	npleted cause of death (Item 23a) (Tue	D30			06-03-20	
4	+VA		Donald R. Ric	hter, M.D	. 1533	8 Memori	al Dri	ve Oakla	and, MD 2	21550
:-	S Regis	tate trar	31. Date filed (Month, Day, Year)			Sperke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** 9:38 AM 22 2005 CYKEITHIA SALLEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Viaryland 8. Date of Birth (Month, Day, Year) April 12 1 General If Under 1 Year If Under 24 Hrs. Has OiTa 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Washington, DC 214-88-5372 42 1963 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f shov or items 23s or 28s-f show 1 Yes 2 □ No Directo Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9408 Pine View Lane 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. other traumatic event, the Medical Examinant Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced **Black** "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Private 12th Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be I Mental Lyndell Conty Barbara Dade P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum <u>once</u>. 9408 Pine View Lane Clinton, Maryland Harry Salley/Husband 20735 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 5/27/05 * 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Fyneral Service Licepsee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Dus to (or as a consequence of): **Examiner** Stoge Reno Sequentially list conditions, if any, Isaamy to immociate cause. Enter Underlying Cause (Disease or injury Due to (or as a capsequence of): certificate be executed signed by the attending physician and debetached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 No certificate 1 Tes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of eartifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/200

State

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Marylan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For State Registrar	e of Maryland	•	rtment of H		, ,	iene	
o Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	3. Time of Death
/Medi Exami		Leonard Henry Swain 4a. Facility Name (If not institution, give street an Fahrney - Kee dy Nu	d number)	4	4b. City, Town, or Boons	Location of Death		4c. County of	Death
Funeral Director		5. Social Security Nbmber 220–05–6797 Cusual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 2	1920 M	B. Birthplace (State or Foreign Country) Jaryland
Maryland a-f show	tor	10a. State 10b. County Maryland Washington	10c. City,	Town or Loc					10d. Inside City Limits 1 ☐ Yes 2X No
be filed within 72 hours after death with the Maryland half Hygiene. Ide Hygiene. In the matural, or items 23a or 28a-f show event, the Medical Everte actional to rotified at	by Funeral Director	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 \(\t \) No 1 - 25 s, Give or Dates: 12 - 20	-44	10f. Zip Code 2171 Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2€ No	spanic Origin? (S n, Mexican, Puen		14. Race	at Country? I States American Indian, White, etc. White
within 72 hours after iene. than "natural", or ite	Completed b	15. Decedent's Education (Specify only highest grade comple	12-20	16a. Deced (Give I life. D	ent's Usual Occupa kind of work done of OO NOT use retired	furing most of wo	rking	16b. Kind of Busi	•
d be filed with ental Hygiene, ked other that c event, that	Be	12 17. Father's Name (First, Middle, Last)		Pres	ss Operat	18. Mother's Na	me (First, Middle, I	Maiden Sumame,	t Industry
INCAIN 10 2 shoul Ilth and Mark 27 is mark r treumati	To	Ieonard Swain 19a. Informant's Name/Relationship (Type, Print Josephine L. Swain_(g Address (Street a	and Number or R		, City or Town, S.	rate, Zip Code)
Definition Pages 1 av permit. Pages 1 av lege_riment of Heal Important: If item any njury or other once.		20a. Method of Disposition **Surial 2 Cremation 3 Removal * 4 Donation 5 Other (Specify)	20b. Pla	ce of Dispos	sition (Name of latory or other place l Cemeter	9)		20c. Location - C	ity or Town, State cown Maryland
DOILE Permit Depurit Imports any nj		21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 32. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the death.	1:	Name and Address 331 Faste or the mode of dying	rn Blvd.	N. Hage	rstown M	Tuenral Home Maryland 21742 Approximate Interval Between Onset and Death
ate be executed Take be executed Thysician and the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a conseque	ance of):	cardio	vascule	ease W. Ase	idst	20×
the death certificate y the attending phys	Physiclan/Me	in the past 12 months?	s, outcome of pregnan Live birth 2 □ Fetal o Pregnant at time of dea Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	,
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The lay ate has page 2	Completed						24a. Was a autops perform	riged? pri	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\text{No} \)
JUISION OT VITAL IN or Attending Physicien: The liter death. Director: After this certificate in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatien 28b. Time of Injury	28c. Injun Work	er: 4 Nursing I	ath (Check only or Home 5 Residence 28d. Describe home		
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To the Hospitel within 24 hours a To the Funeral I completely filled	edical				restigation, in my o	pinion, death occ	urred at the time, d	ate and place, ar	nd due to the cause(s)
To with To	×	29b. Signature and title of certifier				2323		1 /2 8/J	(Month, Day, Year)
4-5+1		30. Name and address of person who completed Dr. Khalid Waseem ME) 1126 Opal	Ct. I		n Maryla	nd 21740		
S Regis	tate trar	31. Date filed (Month Ray, Year)	32. Pegistrar's Signatu		esh				

			For State Registrar	State of M	laryland		artment rtificate			and Mer		giene leg. No.	DOOR	195	and a second
	Physici		1. Decedent's Name (First, Middle, I						-		Date of Dea	ith Day		3. Time of D	
	Physicia /Medic	al	Richard Melvin				4 0	-		171	May	20	County of Deat	5 213	5 M
	Examin	er	4a. Facility Name (If not institution, g						Location o	of Death					
	Funeral		Washington Cour 5. Social Security Number 6		ge (In yrs. Ia	st birthday)	If Under	1 Year			Date of Birth	1	asningt 9. Birt	on Count hplace (State or untry)	CY Foreign
В	Director		215-18-2171	1 X M 2□F	88	Yrs.	Months	Days	Hours		(Month, Day			yland	
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or La	ocation							10d. Inside City	/ Limits
	Mary -f sho	tō	Maryland Washin	aton		Hager	stown	1						1 🗆 Yes 🕽	XX No
	or 28a	irec	10e. Street and Number									10g. Citi	zen of What Co	ountry?	
	ath wil	ral	14014 Marsh Pik												
36	72 hours after death with the Maryland natural', or flems 23a or 28a-f show Jical Essoilier must be notified at	Substance December													
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Maryland	be fill d oth	Be		-									Sumame)		
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	and 2 s lealth ar m 27 is her trau						-							-	
Jre,	of Heal		20a. Method of Disposition			ace of Disponentery, cre	osition (Nan matory or o	ne of ther plac	е)	Date	•	20c. La	ocation - City or	Town, State	
Ë	Pages ment of 8 ant: If its ury or o				e Roc	cky Ga	p Vet	Cerr	etery	y 5–31	- 05	Fl.	instone	Marylar	nd
Baltimore,	permit. Departi		21. Signature of Funeral Service Lie	A. Lui	11.	- 1				DOU					
	/Medical Examiner	aminer	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Apply that initiated events	aDue to (2)	line. s a consequ MUNM	ience of):	Ler the mod	e of dying	g, such as	cardiac or re	espiratory ar	rest,		Approximate Interval Betwoen Conset and Do	reen
. Box 68760,	ath certif	edicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	e of pregnar 2 □ Fetal at time of de	ncy death 3[ear
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	To the k within 24 To the C	Me	29b. Signature and title of certifier						e number				te signed (Mont		
			me					5	232	3		7	127/	1	
4_	7+1		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type 0 pal	Print)	1-+	Ha	940	stou	'n	Mary	land	
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			State of Marylar				-	_	
			For State State Registrar		rtificate of D			1. No. 2 A A G	100010
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		JULIA ALICE STOC	KSLAG	ER		Month MCLY	Day Year 2006	7:20 AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo		ı	4c. County of Dea	
			Washington County Hospit		Hagers			Washi	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2X F 7. Age (In yrs. 93			f Under 24 Hrs. Hours Min	B. Date of Birth (Month, Day, 1	r 13,1911	thplace (State or Foreign ountry) Maryland
		ŀ	Usual Residence of Decedent			- 09	poombo	1 10, 4011	Trai y zarra
	nylan show			ty, Town or Lo					10d. Inside City Limits
	8a-fs	cto	Maryland Washington	Boons					1 X Yes 2 No
	within 72 hours effer deeth with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at	by Funeral Director	10e. Street and Number 141 South Main Street		10f. Zip Code 21713		10	g. Citizen of What C	ountry?
	ns 23	erai	11. Marital Status 12. Was Decedent Ever in U	J.S. 13.			ifv Yes or No-	14. Race - Am	erican Indian,
ယ္	or iten	F	1 Never Married 2 Married 1 Yes 2 No	ĺ	Was Decedent of Hisp If Yes, specify Cuban, 1□ Yes 2X No		ican, etc.)	Black, Whi	
21215-0036	ral', c	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:			Specify:		Specify: M	hite
5-(natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of workin	g 1	6b. Kind of Business	Andustry
12	withlr ene. than	Juno	Elementary/Secondary (0-12) College (1-4or 5+)		memaker			Own Hom	ie
<u>d</u>	Hygi other	Be Co	17. Father's Name (First, Middle, Last)		-	8. Mother's Name	(First, Middle, M	aiden Sumame)	
<u>la</u>	2 should be filed withln and Mental Hygiene. Is marked other than eumatic event, the Ma	To B	Albert Leonard	Stocks	lager	Nellie	А	lice	Welty
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	l and lealth im 27 iher tr		Sue E. Gordon Friend		South Main			oro, Mary.	
or	nt of h		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place)				
Baltimore,	perriit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		*4 □Donation 5 □ Other (Specify) R 21. Signature of Funeral Service Licepsee		ll Cemeter				, Maryland
Ba	Depa Imp any		R. hall Bridg	Ai 40	2. Name and Address ndrew K. Co D East Ant.	offmán Fu ietam Str	neral H eet. Ha	ome, Inc.	Md. 21740
			23a. Part1. Enter the disease, or complication, that caused the dea shock, or heart failure. List only one cause on each line.						Approximate Interval Between
N.	Physician		Immediate Cause (Final disease or condition	la.					Onset and Death 3-4 DAYS
	/Medical Examiner		resulting in death) Due to (or as a conse			/	. ,		J= 1 - 1 - 1
	Lxammer	_	Sequentially list conditions, fauly, leading to immediate	of le	electomy o	ybe 0551	ruetion		3 DAYS
	ted	nine	cause. Enter Underlying Cause (Disease or injury	quarios or,					for Yems.
Ć,	te be executed ysician and ne burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a conse	fT quence of):					FOR TENICS.
190	death certificate be execut e attending physician and od for use as the burial-trar	cal	d.						
89	death certificate I attending physi I for use as the b	by Physician/Medi	IF FEMALE:						
Вох	ath ce ittendi or use	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr	al death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
P.O.	res that the de signed by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				
	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause given	in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
rds	w requires been sign should be	q pe					1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
000	aw Is b	Completed					24a. Was an	24b. Were a	utopsy findings available completion of cause of
R	The law ate has page 2 s	Com					perform	ed? death?	s 2 No
/ita		Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	
of/	Phys this al dii	2	1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatie		4 Norsing Hon	ne 5 Resider	nce 6 Other (Spe	ecify)
Division of Vital Records,	tter ne	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	Work?	es 2 🗆 No	Bu. Describe not	V Injury Occurred	
/isi	Attending or death. ector: Atterby the fune	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, st			8f. Location (Str.	eet and Number or F	lural Route Number,
Ö	s after s after or of Director	Certification:	4 Homicide determined building, etc. (Spec	uty)			City or Town,	State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier (Check only (
	the h	Medical	one) and manner stated.		29c. License			d. Date signed (Mon	```
	To To		29b. Signature and title of certifier			6561	2.5	MM 281	
			30. Name and address of person who completed cause of death (Ite	om 23a) (Tvpa					, , , ,
1-3	2		Gunnara DMIA 20311	LATIPA	V	BOON	sporce	mo 21	713
	St		31. Date liled (Months Day Year) 32. Registrar's Sign	nature					
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		1 - For State Registrar	State of Ma	ryland / Dep Ce	artmen ertificat			and Me		jiene leg. No. 🤈	กกร	1051
Physicis	an	1. Decedent's Name (First, Middle, L						2	2. Date of Dea Month	Day	Year	3. Time of Death
/Medic	al	Emma L.			1 11 21				May 24,	2005		12:45 P. \
after death. If the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit in by the fundral director, page 2 should be detached for use as the burial-transit.	er	4a. Facility Name (If not institution, g	_		4b. City,		Location o				unty of Death	
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		246-24-0445	1□M 2-F	76 Yrs.	Months	Days	Hours		(Month, Day Arrch 6,			ntry) n Carrolina
>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	coation							10d. Inside City Limit
sho	20	D.C.		Too. Oily, Town of t	Location		Washir	gtan				1 ∏X Yes 2 □ N
28a-	rect	10e. Street and Number		<u> </u>	10f. Zip	o Code				10a. Citizer	of What Cou	
3a or	Ö	920 Eastern Aver	ue, N.E. APt.	#202			20019)			S.A.	,
ams 2	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	Was Dece	dent of His	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	14.	Race - Ameri Black, White,	
or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 🍇	0	1 ☐ Yes		Specify:	, 1 4010 111	ioan, 0.0.,		ecify: Blac	
ture!	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	163 Doo	edent's Usu	al Casuas	tion					
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Ment arkac atic	으	Lhans	s Surles						attie M			
is m		19a. Informant's Name/Relationship Janice Smith (Daught		19b. Mai	ling Address	s (Street a	nd Numbe	or or Rural i	Route Numbe	r, City or To	own, State, Zij 34	Code)
lealth am 27 ther t	1	20a. Method of Disposition		20b. Place of Disp				Da			ion - City or T	
nt of h		™Burial 2. Cremation 3		Resurrect	ematory or c	other place	9) Me	ay 28,			on, Mary	
artme ortani injury		*4 □Donation 5 □Other (Special Signature of Funeral Service Lice		1	22. Name ar							
Dep) (, lue	11.	29				. NOI	llins ru shington		bme, In	С.
500		23a. Part1. Enter the disease, or co	mplications that caused	the death. Do not e					_		2001)	Approximate
hvsician		shock, or heart failure. List on Immediate Cause (Final disease or condition		 tic Pancreat	ic Con							Interval Between Onset and Death
Medical		resulting in death)		consequence of):	ic Can	CEL						
aminer		Sequentially list conditions.	b. Preumon									_
sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)		consequence of):								
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sicien a buria												
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use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		□Ectopic p	roonano.				230	. Date of deliv	ery
ne att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 1		Other (sp		-				Month	Day Year
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signe bed	ρχ	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying o	cause give	in in Part I.					he cause of death? cably 4 □Unknow
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ficate rr, pag		or W.							1 Yes	2 1 No	1 🗆 Yes	2 🖾 No
certii	o Be	25. Was case referred to medical examiner? 1 ☐ Yes ②▼ No	Hospital:	nt 2 ER/Outpati	2 ⁻	OA Othe			Chack only of		10shau /C:	6.1
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ath. r: Afte e fun	ertification;	1X Natural 5 ☐ Pending 2 ☐ Accident investigat		Yea <i>r)</i> Injury	м		(? /es 2 □ l	No				
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uner funer ely fill	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best o aminer: On the basis of	if my knowledge, de examination and/or	ath occurred	at the tim	e, date an	d place, an	nd due to the o	ause(s) an	d manner as s	tated.
the f	Med	one)	and manner sta	ted.								
To		29b. Signature and title of certifier		,	29	c. License	50619			ì	igned (Month,	uay, rear)
		20 Nomble	a completed constant	LE, CONNI		IX.	XXXX			5/25	1005	
		30. Name and address of person who Comie Le,	M.D. 1500 Fo	rest Glen R	erint)	ver Sr	nring.	MD.	20910			

		For State Registrar	State of Marylan			of Health of Deat			giene)5	195	17
Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	Day	Year	3. Time of [
Physicia /Medic				PSON				May	20, 20	005	02:44	A^
Examin	er	4a. Facility Name (If not institution, give: Holy Cross Host				own, or Locatio Lver Sp			4c. County	of Death tgome	rr	
Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday)	If Under 1	Year I tf Und	er 24 Hrs.	8. Date of Birt		9. Birthr	place (State or	Foreign
Director		577-98-5319	^{1 M 2} (X)F 28	Yrs.	Months	Days Hours	Min.	8. Date of Birt Jan • 2	3,1977	Cow	äsh. I	OC
ane. than "naturai", or items 23s or 28e-f show i.e Medical Examinat must be notified at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City	. Limits
Department of Health and Mental Hygiene. Important: or items 23s or 28e-f show important: if item 27 is marked other than "natural; or items 23s or 28e-f show any injury or other traumatic event, it is Medical Exacting must be notified at once.	ō	MD Montgo			ensin	gton				'	1¥ Yes	
28e-	Director	10e. Street and Number			10f. Zip C	ode			10g. Citizen of V	Vhat Cour	ntry?	
Sa or	i D	4006 Hampden	Street			208	395		U.	S.A		
E III	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decede	nt of Hispanic (Origin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ	can tndian,	
	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1□Yes X			,	Specify		lack	
N P	q pa	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual	Occupation			16b. Kind of Bu			
dedic	Completed	(Specify only highest grad	completed) Cotlege (1-4or 5+)	(Give	kind of work DO NOT use	done during m retired)	ost of work	ing	100. Kind of De	31110337111	idustry	
11.0	Com	Elementary/Secondary (0-12)	College (1-401 5+)	R	.ecept	ionis	t		Ouris	man	Chev	rolet
N8Ut	Be (17. Father's Name (First, Middle, Last)	1						Maiden Sumam	*	_	
SELEC.	J.	Maurice Stewar		405 14-10					n Hende			
traur		19a. Informant's Name/Relationship (Ty Annie Henderso:							er, City or Town, ensingt			0895
Ogt.		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name matory or oth	of		Date	20c. Location -			
ry or		1 Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	removal from State			. Cem !	5/28/	/05 \$	Sandy S	pri	ng, Mi	D
y inju		7. Signature of Funeral Service Licens	өө /						Funera			
E 2 9	-	TINCH KI	Anoude						cville,	, MD	2085	0
		shock, or heart failure. List only of	lications that caused the deati ne cause on each line.	h. Do not en	ter the mode	of dying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Betw Onset and D	reen
sician edical		Immediate Cause (Fin sides of condition resulting in death)	· Multiple		45145)					011001 01110 0	
niner			Due to (or as a conseq	uence								
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Iransli	Examiner	that initiated events	с.							- 41		
ourial-		resulting in death) Last	Due to (or as a conseq	uence of):								
s the burial-transit	dicai		d									
for use as	w	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome of pregna						23d. Dat	te of delive	erv	
d for	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		□Ectopic pred □ Other <i>(spe</i> d				Mo			ear
tache	hys	9 Unknown	9□ Unknown									
be detached f	by F	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	inderlying cau	use given in Pa	rt I.		obacco use conti			
should	ted							101	res 2 XNo	3 Proc	oably 4 □U	nknown
2 5	Completed							24a. Was	an 24b. V	Vere auto	opsy findings a impletion of ca	vailable use of
certificate rector, pag				_				1 XYes	2 □ No 1	Yes	2 No	
irecto	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2X	EP/Outpatio	nt 3 DOA	Othor		h (Check only o	<i>nne)</i> dence 6 ⊡Oth	or (Consil	6.1	- 1
er this eral dii	h- 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		c. Injury at Work?	ivuising no		now injury occur	ed	06-16	
or: After	atio	1 Natural 5 Pending 2 Accident investigation	5-20-05	0 2:01	O M	1 ☐ Yes 2	X No	INVOLV	d in ac	Cide	tande	ected
To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of tnjury - At he building, etc. (Specif.	ome, farm, st	reet, factory,	office		28f. Location (S City or Tov	Street and Numb	er or Rura	1 11	4.4
lled i				when	rstat	٤.		- 10 -		56	MO	aghts
stely f	Medicai	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exami	sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at rvestigation, i	t the time, date n my opinion, d	and place, leath occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as s and due ti	itated. o the cause(s)	
To the Funerai Director : After this certilicate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c.	License numbe	ər		29d. Date signed	1 (Month,	Day, Year)	
_		DOT DAG	m-16- 100	Och	m	OCME			May 21	L, 20	005	
_		30. Name and address of person who o	ompleted cause of death (item	9 23а) (Туре,	Print)		-					0.05
		PATRICIA J	1 conica - t	OLIAK	~11	1 Penn	Stree	et Balt	imore,	Maryl	Land 21	.201
Sta Registi		31. Date fited (Month, Day, Year) MAY 2 6 201	32 Registrar's Signa	ture do	well .							
TEGISI	- 11	111 TI TO 201	UU I LE LE LE LA LA LA LA LA LA LA LA LA LA LA LA LA		- Branch							

			1 - For State Registrar	State of				of He	ealth a		ental Hy	_	005	1951
į	Physici /Medio		Decedent's Name (First, Middle, L STELLA D. SC	ast) TIRIOU							2. Date of De Month May	ath Day 24	Year 2005	3. Time of Death 5:20 P M
)r - (1) - (1) - (1)	Examin		4a. Facility Name (If not institution, g Mariner Health	of Bethes	da			hesd	la			Mon	ntgome	ry
	Funeral Director		5. Social Security Number 6. 177.38.2084	Sex 7. 1 □ M 2 ☑ F	Age (In yrs.	last birthday) Yrs.	Months	Days	If Under 2 Hours	Mín.	8. Date of Bir (Month, Da Nov. 1	th 19, Year) 3, 1931	9. Birthp. Coun Gree	lace (State or Foreign try) ECE
	be filed within 72 hours after death with the Maryland all hygiene. An expension of other than "natural, or items 23a or 28a-f show event, the Modical Examiner mant he notified all	d by Funeral Director	10a. State 10b. County Maryland Montgo 10e. Street and Number 11004 Conti Pla 11. Marital Status 1 □ Never Married 2 □ Married 3 ─ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	Si		10f. Zip 20 Was Deceddiff Yes, speci	902 ent of His ry Cuban	Specify:	gin? (Spec , Puerto F	cify Yes or No lican, etc.)	Spec	of What Countries • A. ace - Americ lack, White, of	an Indian, etc. te
9500-61212 K	e fited within 72 h Il Hygiene. other than "natu vant, tre Medica	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	Coilege (1-4 2 year		(Give	dent's Usual kind of work DO NOT use	k done du e retired)	uring most			16b. Kind of Clot	hing	dustry
	should be fi and Mental H is marked of sumatic ever	To Be	Naoum Angelido 19a. Informant's Name/Relationship	u		19b. Maili	ng Address		Vi	rgini	a Ang	elidou er, City or Tow		Code)
Baltimore, M	rmit. Pages 1 and 2 should be partment of Health and Menta portant: If Item 27 is marked y injury or other traumatic ess.		Nikolaos D. Sot 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from St.	20b. I	11004 Place of Dispo cometery, creater te of	osition (Nam matory or oti	e of her place)	Da	ver Spr ate /2005	ing, Mi 20c. Location Silver	n - City or To	
L Balti	permit. Departm importa sny inju		21. Signature of Funeral Service Lic	encern	٠.	H 1	Name and INES-F 1800 N	Address RINAI New H	DI F	nire	Ave,	E, INC.		MT) 20904
68/60,	eath certificate be executed Wedical attending physician and for use as the burial-transit	dicai Examiner	23a. Part1. Enter the isease, or conshock, or and filtre. List on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Metast Due to (or b. Hypter Due to (or c. Diabe	atic as a consectensi as a consectes Me as a consectes Me as a consec	Breast quence of): on quence of). ellitus	Cance	r						Interval Between Onset and Death
O. Box 6	0 0	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		h 2 Fetcht at time of c	el death 3	⊒Ectopic pre ☐ Other (spe						Date of delive Month	ry Day Year
rds, P	The law requires that the tee has been signed by thoage 2 should be detache	ed by PI	Part II. Other significant conditions Congestive Hea			sulting in the u	inderlying ca	iuse giver	n in Part I.					e cause of death? ably 4 Unknown
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Division	i Si the G	Certification:	3 Suicide 6 Could not determine	28e. Place of	f Injury - At h , etc. <i>(Speci</i>	nome, farm, st (fy)	reet, factory,	office		2	8f. Location (City or To		nber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Ex	Physician: To the b aminer: On the bas and manne	is of examina		vestigation,	in my opi	inion, deat		d at the time,	date and place	and due to	the cause(s)
	A To Too	2	29b. Signature and title of bertifier	work				License 5	36	91		29d. Date sign	5, 200	
			30. Name and address freeson what Ajay Reddy, M.	no completed cause D., 6320	of death (Ite Democr	m 23a) (Туре, :acy В1	vd, Be	ethes	sda,	Mary:	land 20	0817		
	Sta Registi		31. Date filed (Month, Day, Year)	005 Rec	gistrar's Sign	ature	de)			-				

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygien	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	SPEARMAN	′	2. Date of Death	ay Year 10-20 PM
	Examin		4a. Facility Name (If not institution, give s NAS (LT) C 5. Social Security Number 6. Sex	ADV COVIDST 7. Age (In yrs. last birthda)	4b. City, Town, or Location of De TAWAMA PASC If Under 1 Year If Under 24 H Months Days Hours Mi	IS. B. Date of Birth	c. Country of Death ONTO MEM 9. Birthplace (State or Foreign Country)
	Director		578.38.5960 Usual Residence of Decedent 10a. State 10b. County	M 2⊠ F 85 Yrs.		May 20, 1	920 Detroit, MI 10d. Inside City Limits
	ne Maryla 8e-f shov	Director	Maryland Prince Go		ville		1 ☑ Yes 2 ☐ No
	with the	Dir	10e. Street and Number 918 Karlson Avenu	le.	10f. Zip Code 20783		itizen of What Country?
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "netural", or items 23a or 28e-f show event, I're Medical Erainia et must be notified at	by Funeral			Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	hin 72 hou a. an "netura Medical E	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv	edent's Usual Occupation e kind of work done during most of v DO NOT use retired)	rorking 16b.	Kind of Business/Industry
	filed with Hygiene. other ther				ensed Practical		ealthcare Services
land	ild be fil lental H ked otl ic even	To Be	17. Father's Name (First, Middle, Last) Edward Alexander	Cain	Almeda	ame (First, Middle, Maide Foy	n Sumame)
lary	12 should be and Mental r Is marked c	. 0	19a. Informant's Name/Relationship (Type	pe, Print) 19b. Ma:	ling Address (Street and Number or	Rural Route Number, City	or Town, State, Zip Code)
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic evone.		Clyde Douglas Spea 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	20b. Place of Dis	1/2 South Odgen position (Name of ematory or other place) Memorial Park 5/	Date 20c. I	Angeles, CA 90019 Location - City or Town, State Exville, Maryland
Baltir	permit. P Departme Importen any injur		21. Signature of Funeral Service License	е <u>Н</u>	22. Name and Address of Facility INES-RINALDI FUN	ERAL HOME, I	
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a consequence of):	1 ACTOOSE	ac or respiratory arrest,	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset Interval Between Inte
8760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
.O. Box 6	that the death certificated by the attending properties as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	es pe	d by Ph	Part It, Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
al Records,	The law ate has b page 2 sl	Complete				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital	Physician: Th this certificate ral director, pag	Be o	25. Was case referred to medical examiner?	ospital:	Other	eath (Check only one)	0 T0h - /0 - //
of	Attending Phys r death. ector: After this by the funeral di	atlon; To	1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: Ampatient 2 ER/Outpati 28a. Date of tnjury (Month, Day Year) 28b. Time tnjury	of 28c. Injury at	Home 5 Residence 28d. Describe how inj	
Division	i gite	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	Hospital 24 hours a Funeral I etely filled	edical	29a. Certifier Check only one) Certifying Phys	sicien: To the best of my knowledge, de- ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc	ce, and due to the cause(curred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the l within 2 To the l	Me	29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, Year)
)	5		The second	- PITUSTEETA	N D6130	7 03	MXOMA, PARK.
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	~ D6130 0 CANPOU/	HMUE	MD 20013
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 6 200	Registrar's Signature	with the second		10 70 110

			1 - For Stete Registrar	State of Marylar	•	artment of H			20		100	20
			Decedent's Name (First, Middle, Last)			tineate or E		2. Date of Dea	Reg. No. U	UJ.	3. Time of	Death
	Physici		Barbara McHugh Su					Month	Day	Year		рм
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of De		4c. Cour	nty of Death	9:12	
	Exami	er	Suburban Hospital	,								
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	thesda If Under 24 H		1	ontgor 9. Birthi	place (State ontry)	or Foreign
	Director		169-26-4275]M 2 ⊠ F 80	Yrs.	Months Days	Hours M	in. (Month, Day May 20,			ntry) 18ylvai	
	p.		Usual Residence of Decedent	140-00								
	anylar shov	-	10a. State 10b. County	Toc. Cit	ty, Town or Lo	cation					10d. Inside C	
	Be-f	Director		tgomery	Sil	ver Sprin	ıg	···				2 🖫 No
	with the		10e. Street and Number	Destar		10f. Zip Code			10g. Citizen o		ntry?	
	be filed within 72 hours after death with the Maryland ital Hygiene. so other than "natural", or Items 23e or 28e-f show event, the Medical Evanitier must be notified at	Funerai	3288 Gleneagles	Drive 12. Was Decedent Ever in U	6 12.1	2090		/C**- V N		USA	!!	
	ier de Item	nu	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	.5.	f Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ace - Ameri lack, White,	etc.	
36	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2₺No	Specify:		Spec	eify: Whit	:e	
21215-0036	2 hou		15. Decedent's Edu		16a. Deced	ient's Usual Occupa	ition		16b. Kind of	Business/In	dustry	
215	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done a DO NOT use retired,	luring most of w)	vorking				
21	e filed within al Hygiene. I other than " vent, the Me	Completed	cionomary (5 ·z)	4	Hom	emaker			Own	Home		
pu	be filed stal Hygid ed other event, t	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Suma	ime)		
<u>la</u>	should band Ment s marked umatic e	To	William A. McHug	h			Gv	vendolyn 1	Barnes			
an	2 should be and Mental Is marked creumatic even		19a. Informant's Name/Relationship (Ty)					Rural Route Numbe				
≥,	and ealth m 27	1	Paul F. Sullivan/				les Dri	lve, Silve				06
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury gr other treumatic evance.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R	amoval from State	emetery, cren	sition (Name of natory or other place		Date 27,	20c. Location	ı - City or To	own, State	
Ë	Pag Imeni jury		' 4 ☐ Donation 5 ☐ Other (Specify)	Meta	-	n Crematory		2005 Z	lexand		Virgin	ia
Sall	ermit lepart npor ny in		21. Signature of Funeral Service/License	90	22 F	. Name and Addres	s of Facility Collin	s Funeral	Home	Inc		
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г			23a. Part . Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the deat ie cause on each line.	h. Do not ente	er the mode of dying	g, such as cardi	ac or respiratory ar	est,		Approximat Interval Bet Onset and I	ween
	Physician	6 I	Immediate Cause (Final disease or condition resulting in death)	Cardiac Ar	rest						Oriset and i	Jean
	/Medical Examiner		resulting in death)	Due to (or as a conseq	1							
		_	Sequentially list conditions,	Respirator Due to (or as a conseq		ure						
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated aveat injury	Hypertensi	71. (33.5	rt Diseas	e			- 1		
	xecurand and	хаг	that initiated events resulting in death) Last	Due to (or as a conseq								
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687	that the death certificate be executed ob by the attending physician and detached for use as the burial-transit	edicai										
Box	eath certific attending p I for use as	/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	ancy				23d. D	ate of delive	arv	
ğ	death a atte	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)				fonth		/ear
o	that the de ed by the a detached t	hysi	9 Unknown	9□ Unknown								
Ф.	res that igned to be det	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	iderlying cause give	n in Part !.	23e. Did to	bacco use co	ntribute to th	ne cause of d	eath?
Records,	w require been sig should b							1 🗆 Y	es 2□No	3 ☐ Prob	ably 4 🛣 L	Inknown
000	law requas been 2 should	ojet						24a. Was a		. Were auto	psy findings	available
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Vital		a	25. Was case referred to medical				26. Place of D	eath (Check only or		1 1 1 1 6 3	20110	
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n of	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe h			.,	
Si O	Attending r death. ector: After	atic	2 Accident investigation			M 1 7	es 2□No					
Division	or Att	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory, office		28f. Location (Si City or Town		ber or Rura	I Route Num	ber,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	O										
	Hospital 24 hours a Funeral I tely filled	edical	(Check only 2 Medical Exemir	sicien: To the best of my kno ner: On the basis of examina	wledge, death tion and/or inv	occurred at the timestigation, in my op	e, date and placinion, death oc	ce, and due to the c curred at the time, d	ause(s) and mate and place	nanner as st	tated. the cause(s)
	To the within 2 To the complet	Med	one)	and manner stated.		29c. License						
	vit To con		29b. Signarura and title of certifier	V. Aninia	١	D47			9d. Date sign Mav 2	4, 20		
•	10		Momms	0.103011	1					-, 20		
	ľ		30. Name and address of person who co Thomas Joseph, M.				#207 B	ockville,	MD 20	052		
	Sta	to	31. Date filed (Month, Day, Year)	37 Registrar's Signa	4		π201, R	ocvatite,	MD 20	002		
1/2	Registr		MAY 2 6 200		L Soa	de						

Sullivan, Barbara 5/33/052113 PM

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Wilbert Theodore Shanor May 25 2005 2:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Earleville Cecil 1656 Glebe Road Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year Months Days 8. Date of Birth (Month, Dey, Yeer) **Funeral** Hours 1 X M 2 □ F 194-14-1591 80 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State ir than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director New Castle Newark 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 200 East Village Drive - Room 334 19713 USA death Funeral Rece - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after d il Hygiene. other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: WW 11 Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University Provost 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy important: if item 27 is marked othery injury or other traumatic event, 9069. Be Wilbert Arthur Shanor Wilma Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Shanor/wife 200 East Village Drive - Room 334, Newark, 20b. Place of Disposition (Name of cometery, crematory or other place) 05-27, 2005

R.T. Foard Funeral Home, P.A. 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 22. Name and Address of Facility R.T. Found & Jones, Inc. 21, Signature of Funeral Service Licensee 122 West Main St., Newark, VE Pent 1. Enter the diseluse, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filling. List only one cause of a such line. Approximate Interval Between Onset and Death and Death Immediete Caus Final disease or contion resulting in Fath) Physician /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the attending physicien and ned for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Dther: 4 Nursing Home 5 Residence 6 Dother (Specify) ESI CNCC Hospital: 1 ☐ Inpatient 2 ☐ ER/Dutpatient 3 ☐ DOA 1 Yes 2 No Certification: To funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Beath After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral (1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey Year) 29b. Signature and title of certifier D0056449 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, MD 111 West High St.-St. 302, Elkton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 7 2005 Registrar

			FOI	viaryland	•	partment of H		lental Hy	giene	prod
			1 - State Registrar		Ce	ertificate of l	Death		Reg. No U	5 19522
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of D Month	-	3. Time of Death Year
	/Medic		John Walter Sm		Jr.			May		11.202
	Examin	er	4a. Facility Name (If not institution, give street and number	∍r)			r Location of Death		4c. County o	
			511 Bernard Avenue	Ama (In use In	and thindholes	Greens		0 Data of B		oline
	Funeral		X □M 2□F	Age (In yrs. la	Ven	Months Days	Hours Min.	8. Date of B (Month, D May 1	2, 1923	9. Birthplace (State or Foreign Country) Maryland
	Director		217-12-4253 Usual Residence of Decedent	82	2			May 1	2, 1929	Maryranu
	land ow		10a. State 10b. County	10c. City	, Town or I	Location				10d. Inside City Limits
	Many -1 sh	tor	Maryland Caroline	Gr	eensl	oro				1 XYes 2 □ No
	ar death with the Maryland tems 23a or 28a-f show termust be rollited at	Directo	10e. Street and Number			10f. Zip Code			10g, Citizen of W United St	hat Country?
	h with	al D	511 Bernard Avenue			21639			united 50	America
	deat	Funeral	11. Marital Status 12. Was Deceder Armed Force	nt Ever in U.S	S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spo	ecify Yes or N	o- 14. Race	- American Indian, , White, etc.
٥	or Ite		1 Never Married 2 Married 1 Ves 2 If Yes, Give		13-	1 ☐ Yes 2 ဩ No	Specify:	riioari, etc.)	Specify:	, Willie, etc.
2-003p	filed within 72 hours after Hygiene. Ather than "neturet', or Ite Att. The Modical Examilia.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date:	s: 194	13		opeony.		Specify	Caucasian
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Z	lled v Hygie her t		17. Father's Name (First, Middle, Last)			Mechanic	18 Mother's Name	/First Middl	e, Maiden Sumame	
yland	ntal hed of	Be		. C-a					e Rolliso	
_	houte d Me mark matic	P ₂	John Walter Smith 19a. Informant's Name/Relationship (Type, Print)	ı, sr.	10h Mai	ling Address (Street				T. 0
<u>8</u>	s 1 and 2 sh f Health and item 27 is m other treum									21639
a)	1 an Heal em 2		Frances L. Smith Wife	20b. Pla	ace of Disp	Bernard position (Name of	Avenue,	Gree:	20c. Location - C	Maryland city or Town, State
٥	m O		1 🔀 Burial 2 □ Cremation 3 □ Removal from Sta		ітетегу, сг	ematory or other plac Cemetery	6/2/2			Maryland
IIIMor	nit. Page artment o ortent: If injury or e.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses				1			
g	permit. Page Department Importent: fl eny injury or		* Karel Sur, Nooi	سع	Ī	Moore Fune Denton, M	eral Home,	P.A.,	12 Sou	th Second St
Н	5001		23a. Part1. Enter the dis 1/2 e, or complications that caus shock, or heart failure. List only one calls. In each	sed the death.	. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory	arrest,	Approximate Interval Between
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	/Medical		resulting in death)	as a consequ	ence of):	act conse)			Dice
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õ	eath certifica attending ph I for use as t	Med	IF FEMALE:							
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VITal	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			Out	26. Place of Death	1		
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		lon:	The atolai S Periong	Day Year)	28b. Time Injury	Worl		28d. Describe	how injury occurre	d
<u>s</u>		cat	2 Accident investigation 3 Suicide 6 Could not be 286 Place of	tainer At hai			Yes 2 □No	006	(Carana and Alexandra	and Complete March and
UNISION	or Al after of Direction by	ertification;	determined 286. Place 0	etc. (Specify)	me, rarm, s	street, factory, office			own, State)	r or Rural Route Number,
_	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	O	29a. Certifier 1 Certifying Physician: To the be	est of my knov	vledge, dea	ath occurred at the time	ne, date and place,	and due to the	e cause(s) and man	ner as stated.
	he Ho in 24 ł he Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis and manner		ion and/or	investigation, in my of	pinion, death occurr	ed at the time	, date and place, ar	nd due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License				(Month, Day, Year)
			· lowed Om			D3	988'7		6-1-	05
			30. Name an address of person who completed cause of	of death (Item	23a) (Type	e, Print)				
	1		David H. Smith, M.D.,			ntail Dr	ive, Eas	ston,	Marylan	d 21601
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regi	istrar's Signati	ure	in the second				
	11/2/15/1	C.I.	4. FE FEM	7 -	1251	and the c				

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			For State Registrar	State	of Maryla	•	artment rtificate			and M		Reg. No.	005	195	23
Н	Physicia	an	Decedent's Name (First, Midd	.,,							2. Date of De Month	Day	Year	3. Time of D	
	/Medic		Robert Andrew								May	30	2005	1:55P	М
	Examin	er	4a. Facility Name (If not institution 17040 Melville		umber)				Location o	of Death			ounty of Death		
			5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under	ender 1 Year		24 Hrs.	8. Date of Bi		9. Birthi	place (State or i	Foreign
	Funeral Director		218-44-9149 Usual Residence of Decedent	1 X M 2 □ F	57	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Da Aug 15	1947	Cou	imore,	_
	land ow		10a. State 10b. County	1	10c. C	ity, Town or Lo	ocation							10d. Inside City	Limits
	Mary I-f sh	tor	Maryland Caro	line .	He	nderson	n							1 ☐ Yes 2	2 ∏ No
	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?	
	th wit	aiD	17040 Melvill	e Road			21	640				U.S.A	. •		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, It a Modical Examitter in that be multiled at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Mar 3 □ Widowed 4 □ Divorce	ried Armed F	2 📉 No live		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or Ne Rican, etc.)		Race - Ameri Black, White, pecify:		
ş	thou stura	ed		nt's Education		16a. Dece	dent's Usua	I Occupa	ition			16b. Kind	of Business/In		
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9	e file al Hyg l othe vent,	Be	17. Father's Name (First, Middle	,							(First, Middle	, Maiden Su	ımame)		
<u>a</u>	Menta Menta	To	Arthur M. Sim	on					Petr	a T	orres				
Maryland	2 sho and is mu		19a. Informant's Name/Relation									. ,	own, State, Zip	o Code)	
	and ealth m 27 her tr		Debra Ann Sim	on/ wife	204) Melv				enderso			- 01-1-	
9	ges 1 t of H if ite or otl		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	n State	Place of Dispo			- 1				tion - City or To		
Ē	Pa tmen tant:		° 4 □ Donation 5 □ Other (Gr	eensbor				06/0	3/05	Green	sboro,	Maryla:	nd
Baltimore,	permit Depar Impor any in		21. Signature of Funeral Service	Licensee	la		2. Name and Leegle Box				ein Fur	nera1 21639	Home, 1	PA	
, ·	/Medical Examiner the private and the private the private the private the private that the	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a conse	equence offic	î lu	ing	Can	rce			/	Onset and De YEAF	NonHis
O. Box 68760,	death certifi re attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of preg birth 2 Te gnant at time of nown	tal death 3	∃Ectopic pro □ Other (sp		-			230	d. Date of delive Month	ery Day Ye	ear
ر ال ال	ires that signed t d be det	by	Part II. Other significant condit	ions contributing to	death but not re	esulting in the u	inderlying ca	ause give	n in Part I.			tobacco use Yes 2□I		he cause of dea	
Records,	as been 2 shoul	Completed									24a. Was	s an apsy ormed?	24b. Were auto prior to co death?	opsy findings av	vailable
Vital		a)	25. Was case referred to medic	al					26. Place	of Death	(Check only				
>	5 0 7	To B	examiner? 1 ☐ Yes 2 © No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DO	A Othe	9r: 4 □ Nu	rsing Ho	me 5 ⊠ es	idence 6	Other (Specif	fy)	
ion of	ding h. After tune	ertification; 7	27. Manner of Death 1 Natural 5 Pend 2 Accident invest	/A.6c	e of Injury onth, Day Year)	28b. Time o Injury	of A	8c. Injury Work 1 🔲 \	at ? (es 2 🗆		28d. Describe	how injury o	occurred		
Division	after de Directo	ertific	3 Suicide 6 Could 4 Homicide deten	nined 286. Plat	ce of Injury - At ding, etc. (Spec	home, farm, str cify)	reet, factory	, office				(Street and I wn, State)	Number or Run	al Route Numbe	ə <i>r</i> ,
_	To the Hospital or Attenowithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medice	ing Physicien: To the I Exeminer: On the and ma	ne best of my ki basis of examin	nowledge, deat nation and/or in	h occurred a	at the tim	e, date an pinion, dea	d place, th occurr	and due to the	cause(s) ar , date and pl	nd manner as s ace, and due t	stated, o the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifi	7			29c	. License	number	1		29d. Date s	signed (Month,	Day, Year)	
			▶ mmd <	MUH	1		1	ング	18 Y	1		10/	1/05		
			30. Name and address of person	who completed ca	use of death (Ite	em 23a) (Type,	Print)			+				-	
_			David Smith,	MD 29466	Pintai	1 Drive	e; Eas	ston	, MD_	2160	1				
	Sta Regist		31. Date filed (Month, Day, Yea	8 2005	egistrar's Sig	natula	pared)	•							

377		-	1 - For State Registrar	State o	f Maryland / D	epartmen Certificate			-	giene 2005	19524
	Physici /Medic		Decedent's Name (First, Middle, La Mario Silva-De	,					2. Date of De. Month MAY	15, 2005	1656 P M
	Examin	er	4a. Facility Name (If not institution, gir DORCHESTER GENER 5, Social Security Number 6.			CAMI	BRIDGE	cation of Dea T f Under 24 Hr		4c. County of Dea	ER
	Funeral Director		None Usual Residence of Decedent	1⊠M 2□F	44	rs. Months		Hours Mir		y, Year) Hon	rthplace (State or Foreign ountry) duras
	deeth with the Maryland rms 23a or 28a-f show r must be notified at	ector	10a. State 10b. County MD Talbot 10e. Street and Number		10c. City, Towr		Code			10g. Citizen of What C	10d. Inside City Limits 1 Yes 2 No
	23a or	Funeral Director	3634 Gate Street			2	21662			Honduras	
920	after or ite	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 [Yes If Yes, Giv Year or D	X□ No			anic Origin? (Mexican, Pue Specify: Hot	Specify Yes or No orto Rican, etc.) nduran	Specify	
Maryland 21215-0036	n 72 hc	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	Decedent's Usua (Give kind of wor life. DO NOT us Construc	rk done dur se retired)	ing most of w		16b. Kind of Business	
nd 2	s 1 and 2 should be filed within 't Health and Mental Hygiene. item 27 is marked other then other traumatic event, the Men	Be	17. Father's Name (First, Middle, Las	t)		CONSCIU		8. Mother's Na	ame (First, Middle,	Maiden Sumame)	
aryla	should and Men s marke tumatic	၉	Unknown 19a. Informant's Name/Relationship	(Type, Print)		-		d Number or F	Rural Route Numbe	.lva-Doming er, City or Town, State,	Zip Code)
	1 and 2 Health a sem 27 l		Luis Torres 20a. Method of Disposition		20b. Place of	Disposition (Nan	ne of	e Unit	18; Trap	ope, MD 216	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra 900.		1 Burial 2 □ Cremation 3 (14 □ Donation 5 □ Other (Spec	ify)	State	y, crematory or o Rita Cer	netery			Santa Rita	
Ball	Departi Departi Import any in		21. Signature of Euneral Service Lice 23a. Part1. Enter the disease, or cor	Fly	<u></u>	Lome, PA	; PO I	Box 160); Greens	d Helfenbe sboro, MD 2	
8760,	whysician and white burial-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	of):	12 2 20	les .			Inierval Between Onset and Death
.O. Box 68	death certific e ettending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live t	tcome of pregnancy birth 2 ☐ Fetal death nant at time of death own	3 □Ectopic pr 5 □ Other (sp				23d. Date of de Month	elivery Day Year
4	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions	contributing to d	eath but not resulting in	the underlying c	ause given	in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 ☐ F	to the cause of death? Probably 4 □Unknown
al Reco	The law ate has b page 2 si	Completed			-				24a. Was autor perfo	an 24b. Were a prior to death?	autopsy findings available completion of cause of s 2 No
f Vit	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2 ER/Ou	tpatient X DO	Other:	4 🗆 Nursing	eath <i>(Check only c</i> Home 5 ☐ Resi	one) dence 6 □Other (Sp	ecify)
Division of Vital Records,	or Attending fter death. Sirector: After in by the fune	Certification:	27. Manner of Death 1 Natural 5 Pending investigative structure 4 Homicide	on 5-19 be 28e. Place	th, Day Year)	.12.PM	8c. Injury at Work? 1 Yes	t s 2⊠No	28d. Describe I December Volume 28f. Location (City or To	how injury occurred L pouseur L n cell is Street and Number or F wn, State) 1550 & Crn. Dorch	COV Gural Boute Number WMEDWOOD Rd
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical		miner: On the b	e best of my knowledge easis of examination an iner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	N	\		OCME			,	2005
			30. Name and address of person who	completed cau	se of death (Item 23a)	Type, Print) 111	Penn	Street	Baltim	ore, Maryl	and 21201
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 6	20.5	registrar's Signature						

		•	FOI	epartment of Health and M Certificate of Death		ene 2005	19525
	Physicia /Medic		Decedent's Name (First, Middle, Last) SELMA W. SCHWARTZ		2. Date of Death Month MAY	Day Year 20, 2005	3. Time of Death 6:50PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			CARRIAGE HILL NURSING HOME 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	BETHESDA day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	MONTGOME 9. Bir	TRY thplace (State or Foreign
	Funeral Director		577-60-6829 1□ M 2対 F 93 Yr. Usual Residence of Decedent	Months Days Hours Min	8. Date of Birth (Month, Day, Y 10-28-1	911 N	IEW YORK
	yland how		10a. State 10b. County 10c. City, Town of	or Location		<u></u>	10d. Inside City Limits
	Ba-f s	ctor		LVER SPRING			1 XYes 2 No
	with the	Directo	105. Street and Number 10509 GEORGIA AVENUE	10f. Zip Code 20902		. Citizen of What Co U . S . A .	ountry?
	ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or ltems 23a or 28a-f show marked other than "natural", or litems 23a or 28a-f show maric event, the Medical Examinar must be notified at	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes, Give A 3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Hican, etc.)	Specify: WH	
2-003	72 hou natura ical E	ted	15. Decedent's Education 16a. D	ecedent's Usual Occupation Give kind of work done during most of worki	na 16	b. Kind of Business	/Industry
2121	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired) CUTIVE SECRETARY		U.S. GOVE	DIMENT
0 0	filed v Hygie othar t ent, th	0	17. Father's Name (First, Middle, Last)		(First, Middle, Ma		KIMENI
Maryland	ould be Mental arked o	To B	ABE WEINER	BELLE		GOLLER	
Man	12 sho h and 7 ls mu irsum		11111	Mailing Address <i>(Street and Number or Rur</i> a 91 WILLIAMSBURG LANE			
ē,	Healt Healt tem 2		20a. Method of Disposition 20b. Place of D	isposition (Name of		c. Location - City or	
altimore,	Pages Int: If i		1 \Rightarrow Burial 2 \Boxed Cremation 3 \Rightarrow Removal from State `4 \Boxed Donation 5 \Boxed Other (Specify)	vidential vision or other place) vidential vision of the place) vidential vision of the place)	/2005 F	ALLS CHUR	CH, VA
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 Is marked eny injury or other traumatic events.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility EDWARD SAGEL FUNERA 1091 ROCKVILLE PIKE	L DIRECT	ION, INC.	0852
Г	- 6		23a. Part 1. Enter the disease, or complications that caused the beath. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEA				Onset and Death
E	Examiner		HVDEPTENCIVE H				
	sit sit	lner	frany, leading to immediate cause. Enter Underlying Due to (or as a consequence of)		***		
	and al-tran	Examiner	Cause (Disease or Injury that infitiated events resulting in death) Last C. CORONARY ARTER Due to (or as a consequence of)				
3760,	ate be executed hysician and the burial-transit	edical E	d. END-STAGE RENA	L DISEASE			
Box 6	eath certifica attending pl	an/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of de	livery Day Year
P.O.	that the dea led by the al detached fo	Physiclan/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Nona	Juy Tour
	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		cco use contribute to	o the cause of death?
Records,	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Completed			24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
<u>ra</u>		Φ	25. Was case referred to medical	26. Place of Death	·	No 1 Yes	3 2 □ No
> <	Physici this ce al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.			e 6 Other (Spe	ecify)
ono	Attending Physician: r death. sctor: After this certific by the funeral director,	tlon:	27. Manner of Death X Natural 5 Pending 28a. Date of Injury 28b. Tim In		28d. Describe how	injury occurred	
Division of Vital	I or Attendi after death. Director: A in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
_	To the Mospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, control to the basis of examination and/control and manner stated.				
	To the H within 24 To the F complete	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Mont	th, Day, Year)
}	5		Nous V. Posque	D0047330		5-23	-2005
	_		30. Name and address of person who completed cause of death (Item 23a) (Ty THOMAS V. JOSEPH, M.D., 50 W. EDMO)		IF MD 24	1852	
	Sta	- 1	31. Date filed (Month, Day, Year) 39. Registrar's Signature	hale	اک ۱۹۱۷ و عاما	JOJ 2	
	Registr	ar	MAY 2 5 2005 Bour 15 19				

	•	For State Registrar		State o	f Maryl	and / Depa	artment o	of Health and of Death		Reg. No.		19526
Dhyciaia		1. Decedent's Name	(First, Middle, La	ast)					2. Date of De Month	aath Day	/ Year	3. Time of Death
Physicia /Medica	al L	DANIEL					STRY		MAY 19			8:25 AM
Examine	r	4a. Facility Name (If r	_		mber)		4b. City, To	wn, or Location of Dea		4c.	County of Death	
		6523 OLD 5. Social Security Nur		ANE Sex	7 Age (In)	yrs. last birthday)	If Under 1 Y	ROCKVILLI Year If Under 24 Hrs	S. 8 Date of Ri	rth		ONTGOMERY
Funeral Director		557-76-204		M∏M 2□F		1 Yrs.		ays Hours Min		ay, Year) 1964	CALTE	lace (State or Foreign try) ORNIA
0		Usual Residence of D					1					
how		10a. State	10b. County		10c.	. City, Town or Lo	ocation				11	0d. Inside City Limits 1 X Yes 2 □ No
89-f s	cto	MARYLAND	MONTGO	MERY		ROCK	VILLE					
vith th		10e. Street and Numb					10f. Zip Co			10g. Citi	izen of What Coun	
s 23a	a a	6523 OLD F	TARM LAN	12. Was Dec	adost Ever	in I i C 12	Was Deceden	20852		0-	U.S.A.	
item	un.	11. Marital Status 1 Never Married	d 2X Married	Armed Fo	rces?	13.	If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	rto Rican, etc.)		Black, White,	
urs af	ò	3 ☐ Widowed 4		If Yes, Gir Year or D	ve		1 ☐ Yes 2 ∑	No Specify:			Specify: WHI	TE
2 ho	ted		15. Decedent's E	Education rade completed)		16a. Dece	dent's Usual C	Occupation	orkina	16b. Ki	ind of Business/Inc	dustry
thin 7	nple n	Elementary/Second		College (1-4or 5+)	life.		done during most of wo retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
ed w ygier ygier t, tr	် ပ	17.5	7	5+			PHYSI		ıme (First, Middle		ERAL GOVE	RNMENT
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name <i>(F</i> LUBERT STR		(1)					HEKTOEN			
Lai yialiu Z IZ IZ-0000	٥	19a. Informant's Nan		(Type, Print)		19b. Maili	na Address (S	Street and Number or F				Code)
Man dd 2 s tth an traun		DR. STACY						ARM LANE, F				20852
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other then "netural", or items 23a or 28e-f show any injury or other traumatic avant, the Medical Exa. It at I was be nealthed at once.	1	20a. Method of Dispo	osition		20	b. Place of Dispo cemetery, cre			Date		ocation - City or To	wn, State
Dealtillion Department of Mportant: If it any injury or o		1 ☐ Burial 2 🔯			State	TIONAL (4/2005	FALT	S CHIIRCH	. VIRGINIA
mit. Foortan	ï	21. Signature of Fund			1,112	2:	2. Name and	Address of Facility				VIRGINIA
B B B B B		CONN	(M)			10	091 ROC	SAGEL FUNEF CKVILLE PIK	E, ROCK	VILLE	N, INC. E, MARYLA	ND 20852
		23a. Part1. Enter the shock, or heart	e disease, or con failure. List onl	mplications that o	caused the c	death. Do not en	ter the mode o	of dying, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
Pnysician		Immediate Cause (F	inal	_ GLIO	BLASTO	MA MULT	IFORME					Onset and Death 1 YEAR
/Medical Examiner		resulting in death)	-			sequence of):						
	<u>.</u>	Sequentially list cond	ditions,	b. Due to	/or 25 2 000	sequence of):						
ted	nine	Sequentially list conditions, leading to immoduse. I have controlled the conditions of the conditions	nediate njury	Due to	(01 40 4 501	1004401100 01/.						
execunate and and all-tra	Examiner	that initiated events resulting in death) La	ast	c. Due to	(or as a con	sequence of):						
icate be executed physician and sthe burial-transit	dlcall		•	d								
tifficat tifficat as th		-									-	-
wrequires that the death certifues that the attending should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent		23c. If yes, ou 1 ☐ Live I	tcome of prebirth 2 🔲		∃Ectopic preg	nancy			23d. Date of delive Month	ry Day Year
e dea the at	Sic	in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregi 9□ Unkr	nant at time lown	of death 5[Other (spec	ity)		Ì	WOTH	Day
that the ed by th detache		Part II. Other signific	cant conditions	contributing to c	leath but not	t resulting in the I	inderlying cau	se given in Part I	23e Did	tobacco i	use contribute to th	ne cause of death?
signe d be d	l by	t at the state of significant						oo garaa aa aa aa				ably 4 Unknown
law requires as been sign 2 should be	Completed								24a. Wa:	20	24h Were auto	psy findings available
has ge 2 s	d E								auto perf	opsy ormed?	prior to cor death?	npletion of cause of
VII.dl Net Sician: The taw serificate has birector, page 2 s	ပိ	25. Was case referre	ad to medical					26 Place of De	1 🙀 Yes ath (Check only	2 No	1 🗆 Yes	2 No
Or VILA Physician: this certific ral director,	o o	examiner?		Hospital:	Inpatient	2 ER/Outpatie	nt 3 DOA	Othor	9.5		6 □Other (Specify	()
_ m o o	i.T	27. Manner of Death		28a. Date		28b. Time o		: Injury at Work?	28d. Describe			,
r Attanding for death. iractor: After by the fune	atlo	1 X Natural 2 ☐ Accident	5 Pending investigati	ion	,,	-,,,	M	1 ☐ Yes 2 ☐ No				
IVIS r Atta ter de iracte iracte	ertification:	3 Suicide 4 Homicide	6 Could not determine	289. Place	e of Injury - ling, etc. (St	At home, farm, st	reet, factory, o	office	28f. Location City or To	(Street an wn, State	nd Number or Rura)	l Route Number,
Urs af	0	1										
To the Hospital or Attandin, within 24 hours after death. To the Funeral Director: Attorney completely filled in by the fun	Medical			eminer: On the b				the time, date and place my opinion, death occ				
o the ithin 2 o tha	Mec	29b. Signature and t	title of confiner	andma	iller stated.		29c. L	icense number		29d. Da	te signed (Month,	Day, Year)
F 3 F 8			~/N/	of no			E	29675		MAY	19, 200	5
50		30. Name and addre	iss of person wh	o completed cau	se of death	(Item 23a) (Type	, Print)					
		RALPH V.		M.D. 6	6420 R	OCKLEDGE	E DRIVE	SUITE 41	00, ВЕТІ	IESDA	MARYLA	ND 20817
Sta		31. Date filed (Month	h, Day, Year)	300	Registrar's S	Signature	aske)					
Registra	ar	MIA	4Y 25 7	MUZ K	COLRA	10- 10/1						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 May 24 1:35 P M Tyeryar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Northampton Manor Hursing Home Frederick If Under 1 Year if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. 6, Director 219-14-9866 80 Maryland Usual Residence of Deceden the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "---- any njury or other traument." 0 or items 23a 200 E. 16th Street 21701 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Pharmacist Assistant Medical Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Shafer Effie Wiles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Naille / Daughter 1018 Dulaney Mill Drive Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 27 2005 * 4 □ Donation 5 □ Other (Specify) Zion Lutheran Cemetery Middletown, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Recurrent Immediate Cause (Final Physician Y20 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, I arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2X No Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred After Injury 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 21944 25/05 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUG #204 S 1475 TAUGY GN350 31. Date filed (Months 44.) trar's Signature 32. F 2005 Registrar

		State of Maryland / Department	artment of Health and Martificate of Death	Mental Hygie	4000	19528
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Physicia	an	James E. Taylor		Month	Day Year 2005	1422 M
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 28, 2	4c. County of Deatl	
Examin	er				Allegany	
Euporol		Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cumberland If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birtl	hplace (State or Foreign
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permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 28s or 28s-f show any injury or other treumatic event. The Medical Examinat must be notilled at an once.		21. Signature of Funeral Service Licensee	Fre	edlock F	uneral U	Home
_ 405 # Q		11 - Fred Miles	31 Jones St. P.	iedmont,	WV 267	
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To the To the To the Comp	X	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month	n, Day, Year)
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Registi	rar	JUN - 1 2005 Store &	2042			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** May 21 2005 11:20 A M Thomas Sr. Riordan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Chever1y Prince George's Hospital Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 960 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 (XIM 2 □ F Yrs. 45 Director February Georgia 216-68-2432 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
and: if item 27 is marked other than "natural", or items 23a or 28a-1 show and the notified any or other traumatic event, it is Medical Examined man the notified any or other traumatic event, it is Medical Examined. 1√2 Yes 2 □ No Director Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4203 Lakeview Drive 20748 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Carpenter Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John C. Thomas Sr. Juanita Farmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa Thomas/Wife 4203 Lakeview Drive Temple Hills, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 5/27/05 Suitland, Maryland ` 4 □ Donation 5 □ Other (Specify) J. B. Jenkins Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence WHE A DAN PH Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 000 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 1 Yes this certificate 2 No funeral director, 25. Was-case referred to medical 26. Place of Death (Check only one) Be niner1 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Yes 2 No Mate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred an er of Death Certification After Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation ccident Director: 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hor o the Fune (Check only one) and manner stated. 29d Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 3 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name CATEVENIS 3001 HOSPITAL JAMES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 MAY 2 7 Registrar

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		- Registrar	2. Date of	Reg. No. 3. Time of Death
Physici /Media	an	Decedent's Name (First, Middle, Last) Marie Thompson	Month May 2	Day Year 2:29 P M
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yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I the alth and Mental Hygiene itiem 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, Ite Madral Extended returned to a partitle of a second other traumatic event.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never Married 1 Never Married 1 Never Married	nic Origin? (Specify Yes or Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: Black
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		James Thompson - husband 20a. Method of Disposition 1 Burial 2XX remation 3 Removal from State 342 Rickey Average A	e. #222, Terr	20c. Location - City or Town, State
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permit. Pag Department Important: any injury		21. Signature of Funeral Service Licensee 22. Name and Address of 6503 Old Br 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, second, or heart failure. List only one cause on each line.	Dall Dass	neral Home, P.A. mple Hills, MF 20748 Approxima e
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The lav	E							autopsy performs 1 Yes 2	id?	death?	mpletion of cause of
vicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death (Check only one			
Physiclen: rthis certificaral director,	To	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 🛣 ER/	Outpatient	3□ DOA	Other: 4 Nur	rsing Home	5 🗆 Residen	ce 6 🗆 O	ther (Specif	y)
ng P.		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury 28t (Month, Day Year)	D. Time of Injury		. Injury at Work?	1	d. Describe how	injury occu	irred	
*Attending Physicien: The I are death. rector: After this certificate he by the funeral director, page	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 N	_				
or At after of Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, tarm, stre	et, factory, o	ffice	28	City or Town,		iber or Hura	I Route Number,
spitei ours a nerei		29a. Certifier Certifying Phy	/sician: To the best of my knowled	dge death	occurred at t	the time, date and	d place, an	d due to the cau	se(s) and n	nanner as s	tated
To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	and/or inv	estigation, in	my opinion, deat	h occurred	at the time, dat	and place	, and due to	the cause(s)
To th To th compl	₹	29b. Signature and title of certifier			29c. L	icense number		290	1. Date sign	ed (Month,	Day, Year)
(4)		1 Kata Pa	ble no			D0047707		ng da phi ng da	5/23/	05	
Se		30. Name and address of person who o	ompleted cause of death (Item 23	a) (Type, F	Print)						
,W		Rita Pabla M.D	. 13621 Baltimor	e Ave	enue L	aurel, M	laryla	and 2070	7		
St Regis	tate trar	31. Date filed (Month, Day Year)	32. Registrar's Signature								

State of Maryland / Department of Health and Mental Hygiene 19532 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month **Physician** Teeter Hester Eleanora 27 2005 12:20 A May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 09/28/1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 ☐ M 2 🖾 F 83 Yrs West Virginia Director 232-26-2824 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, it s Medical Examinar must be notified at 1 ∑Yes 2 ☐ No MD Allegany Cumberland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. Liberty Street 21502 **USA** death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene Important: if tiem 27 is marked other than "natural; or Iten any injury or other traumatic event, the Medical Exemples Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Wellington Tusing Mary Emsev Ruckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Liberty Street, Cumberland, Maryland 21502 Kevin D. Teeter / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🂢 Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 06/01/2005 ` 4 ☐ Donation ☐ Other (Specify) LaVale, Maryland 21. Signatur of F neral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home. P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stroke /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Cardiopulmonary Arrest Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month ō Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No Yes To the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 2 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending investigation s after oc. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0062429 May 27, 2005 ر 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Memorial Avenue, Cumberland, Maryland 21502 Ageel Saleem, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 1 2005 Registrar

			For State Registrar	State of	Marylan	•	artment of H rtificate of		ind Mental I	lygiene Reg. No	005	195;	33
	Physici	an	Decedent's Name (First, Middle	, Last)					2. Date of Month	Da	•	3. Time of I	Death
	/Medic Examin		Siv V. Taing 4a. Facility Name (If not institution	, give street and numb	ber)		4b. City, Town, o	r Location o	May f Death		2005 County of Death	1357	
	LAdiiiii	CI	Suburban Hosp	ital		_	Bethe				Montgome		
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 ☑ F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month	Birth Day, Year,	9. Birth	place (State or ntry)	Foreign
	Director		578-04-7079 Usual Residence of Decedent		91				Marci	15,1	1914 Can	nbodia	
	within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28a-f ehow te Medical Exerciter must be notillised at	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside Cit 1 ☐ Ye <i>s</i>	
	the Mi	ecto	Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code							10g Ci	tizen of What Cou		
	3a or	I DI	330 University	Bouloward	Fact			20901			JSA	nuy:	
	ems 2	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13.			gin? (Specify Yes or , Puerto Rican, etc.		14. Race - Ameri Black, White		
36	s after		1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced		2 🔯 No		1□Yes 2⊠ No	Specify:	,		Specify:	, 0.0.	
21215-0036	2 hour	Completed by	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	oation		16b. F	ASi (ind of Business/Ir		
215	thin 7.	nple	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4	4or 5+)	(Give	kind of work done DO NOT use retire	during most d)	of working				
72	iled w dygier ther th		0 17. Father's Name (First, Middle,	(ast)		Homen	aker	18 Mothe	r's Name (First, Mid		Own Home		
and	ld be fental liked of	To Be	Kon Taing	2201/				Po			, camano,		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or oper traumatic event, Ite Medical Examiner must be notified all once.	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street		r or Rural Route Nu		or Town, State, Zi	p Code)	
Σ,	and 2 ealth in 27 I		You Eng Tea	Daught	er	8824_	Tuckerma	n_Lane				20854	
Baltimore,	or et al		20a. Method of Disposition 1 XBurial 2 Cremation		.	cemetery, cre	osition (Name of matory or other pla [emorial_	сө)	Date	20c. L	ocation - City or T	own, State	
Ħ	artmer ortant injury		4 □ Donation 5 □ Other (S21. Signature of Funeral Service		ļ., OZ		Park 2. Name and Addre		May 27,200	05_01r	ney, Mary	land	
Ba	Depa Impo any ii		D. Ken 5 Kilos			Fr	ancis J.	Colli	ns Funera	al Hon	ne, Inc.	MD 200	Ω1
T.	Physician		23a. Rat1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. COROMAN ATTERY DISEASE										
В	/Medical Examiner		,	Due to (or as a consequence of): CONGESTIVE HEART FAILURE									
		ner	Samuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	to (or as a consequence of):								
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dunta (a	or as a conseq	russes of							
8760,	ate be executed hysician and the burial-transit			Dua to (o	ii as a conseq	quanto or).							
9	ifficate g phys as the	edic		d									
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 monts? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					у		23d. Date of delivery Month Day			
rds, P		by	Part II. Other significant conditi	ons contributing to dea	ath but not res	sulting in the u	inderlying cause gr	ven in Part I.			use contribute to	the cause of debably 4 🗆 U	
Division of Vital Records,		Completed							a	Vas an utopsy erformed? es 2	death?	opsy findings a ompletion of ca	available ause of
Vita	siclan certifi rector	Be c	25. Was case referred to medica examiner?	Hospital:			Ott	200	of Death (Check of			104 ===	
ón of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	27. Manner of Death 1 Natural 5 Pending 2 Natural 5 Pending 2 Accident investigation 2 Pending 3 Natural 5 Pending 4 Natural 5 Pending 5 No Natural 5 Pending 6 No Natural 1 Pending 7 No Natural 1 Pending 8 No Natural 2 St. Injury at Work? 9 No Natural 1 Pending 1 Pe								(Ty)			
Divis									on (Street a Town, Stat	reet and Number or Rural Route Number, n, State)			
	he Hospi n 24 hour he Funera pletely fills	edical	29a. Certifier 1 Certifyin (Check only one) Medical	ng Physician: To the l Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the to	me, date an opinion, dea	d place, and due to th occurred at the ti	the cause(s	s) and manner as nd place, and due	stated. to the cause(s))
	To the Comp	M	29b. Signature and title of certific	12-	In.	^	29c. Licen				ate signed (Month		
•)		1 0	un in	100	13		027	124		5/24	105	
	-		30. Name and address of person					202	70.00m 0 m to	. W=	1 00	107/	
	Sta	ate	Truong Bao, M. 31. Date filed (Month, Day, Year	ມ. 13219 2. Re	EXECU	ature	ark Terr	ace (Germantow	ı, Mai	cy⊥and 20	18/4	
	Regist	rar	MAY 25	2005 Sect	egistrar's Sign	STE							

	State of Maryland / Department of Health and Mental Hygiene 1 - State State State State Certificate of Death Seg. No. 2015 19531.										10501		
	Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of Dea				Reg. No U 3. Time of Death		
	Physici		Dorothea Tierney					May 21					
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or		ath	4c. County of Death					
			Fox Chase Nurs			Silver			Montgomery				
	Funeral Director		5. Social Security Number 6. S 082-03-0770 1	9x	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Mi	n (Month Day	1909	Cou	place (State or Foreign ntry) W York		
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation					10d. Inside City Limits		
	a-f sho	ctor	MD Montgo	·		Spring					1 ☐ Yes 2 X No		
	th with the 23a or 28	Funeral Director	10e. Street and Number 2015 East West	Highway		10f. Zip Code 209	910	1	0g. Citizen o U 3		ntry?		
980	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show amy injury or other traumetic event, the Medical Exacts at most be rediffed at once.	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l I	Vas Decedent of His i Yes, specify Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		ace - Americ lack, White, cify: W			
21215-0036	iin 72 ho n *natur Nedicul	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of w	rorking	16b. Kind of	Business/In	ndustry		
212	ad with	Com	1 2	College (1-4or 5+)	H	omemakei	C		OWI	n Hom	ne		
Maryland	ld be filk ental Hy ked oth ic event	To Be (17. Father's Name (First, Middle, Last) John Nordquis					ame (First, Middle, unknowr		ime)			
ary	shou and M s mar		19a. Informant's Name/Relationship (7	**	1			Rural Route Number					
Σ 	and 2 ealth m 27 i		Marcia Mares/I			The Total Control of the Control of	r Driv	e #201 S					
altimore,	Pages 1		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	metery, cren	sition (Name of natory or other place ake Crer			20c. Location Belts		.e, Md.		
Balti	permit. Departn Importa any inju		21. Signatur uneral Service Lice	De -				DI FUNER			E,P.A. g,Md20910		
	Priysician /Medical Examiner		23a. Part 1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Preumoni. Due to (or as a consequ	. Do not ente						Approximate Interval Between Onset and Death 2wks		
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dementia 1yr Due to (or as a consequence of):									
8760,	licate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c									
.O. Box 68	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ast 12 months? 2 No Only Interesting 2 Person of the control of						Date of deliver	ery Day Year		
Ω.	quires that n signed b uld be deta	by	Part II. Other significant conditions o	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con							he cause of death?		
Division of Vital Records,		Completed						24a. Was a autops perform	sy	were auto prior to co death? 1 \(\sum \text{Yes}	ppsy findings available impletion of cause of		
Vita V	Attending Physician: The death. ector: After this certificate oy the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death (Check only one)						
o	Phys r this ral dir	. To	1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								(5)		
ion	nding Ph tth. :: After th e funeral	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Work	Work?			in an				
Divis	or Attendate death after death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	eet, factory, office 28f. Location (St City or Town			Street and Number or Rural Route Number, rn, State)						
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Co	29a. Certifier (Check only one) 1 X Certifying Ph 2 Medical Exam	ysician: To the best of my know tiner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and pla inion, death oc	ce, and due to the c curred at the time, d	ause(s) and nate and place	nanner as s	stated. o the cause(s)		
	To the within To the compl	Me	29b. Signature and title of certifier			29c. License D28	number 3656	2	9d. Date sign Ma	ed (Month, 23,			
	-		30. Name and address of person who Ravi Pessi MD	completed cause of death (Item 8609 Seco			ite 40	4B Silve	er Spr	ing,	Md 20910		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 5 200	2. Registrar's Signati	ure	E							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Mildred Ullerv 25. 10:10A M 2005 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Memorial Hospital Cumberland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 25, 1928 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Country) Months 1 □ M 2 □ F 217-28-0224 76 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event. The Madical Examinar must be notified at MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 Lexington Avenue 21502 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural, or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Wesley Pyles Rosa Ellen Tracia Fraly Pyles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: if Item 27 ie rr any injury or other treum Michael Ullery 710 Greenway Avenue Cumberland MD 21502 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 5/28/2005 Cumberland MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death marth les Discher Acufe Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Intership Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): ate has been signed by the attending physicien page 2 should be detached for use as the buria' Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Z Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060478 May 25, 2005 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1RW 625 Kent Avenue Cumberland MD 21502 Afag Ahmad M.D. 32. Registrar's Signature State Registrar MAY 2 7 2005

December November Park Metters Care Manual Care				1 - For Amend Item	State of Ma 24a per	ryland / Depa verb., G86	artment of	Health a Q5dbh n	nd Me		giene Neg. No. 20	05	19536	
May 19	6	Physici	an								Day	Year		
126.43 Coordiview Lame, S.E. Little Orleans December Composition Control C		/Medic	cal	John Van Gerder						May 19, 2005 1:				
Second Security Functions Calcal Control C		Examir	er											
Committee Comm		Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Yea	r If Under 2	4 Hrs.	8. Date of Birth	1		place (State or Foreign	
The part of the pa		Director		026-28-8753	M 2□F	67 Yrs.	Months Days	s Hours						
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MELVIP RUSSELL Williams

		•	For State Registrar	State of Maryland /	-	tment of H		l Mer		00	17 500	, ,,,
	4		Decedent's Name (First, Middle, Last)					2.	Date of Death	g. No.	50	3. Time-of Death
	Physici /Medic		Melvin Russel	1 Williams	S				Month	Day 200	Year 5	1:31PM
	Examin	er	4a. Facility Name (If not institution, give st. Doctor's Communi	,		4b. City, Town, or Lanhan		ath	,	4c. County of		orge's
	Funeral Director		5. Social Security Number 6. Sex 1 🕱	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8.	Date of Birth (Month, Day, nuary	Year) 5 1933	9. Birthpi	lace (State or Foreign try)
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36	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Ever in artifast be incitifed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba	ispanic Origin? In, Mexican, Pu Specify:	(Specify erto Ric	/ Yes or No- an, etc.)	14. Race		etc.
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	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type Joyce L. Williams			Address (Street : Frankfor						•
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Itim	Pa nen ant;		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	Rive		Cremato Name and Addres		28/2		Riverdal	-	•
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	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failty. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do cause on each line. Due to (or as a consequence)		the mode of dyin	g, such as card	iac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
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ion	ittending Ph death. ctor: After thi / the funeral	atior	1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl	k? Yes 2□No			,a.,		
Division	al or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f.	Location (Stre City or Town,	eet and Number State)	or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier (Check only one)	cian: To the best of my knowled er: On the basis of examination a and manner stated.	lge, death o and/or inve	occurred at the tin estigation, in my of	ne, date and pla pinion, death oc	ice, and curred a	due to the car at the time, dat	use(s) and manr te and place, an	ner as sta d due to	ated. the cause(s)
	Vithii To the	Me	29b. Signature and title of certifier	C P		29c. License		_	29	d. Date signed (Month, E	Day, Year)
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			30. Name and address of person who con	npleted cause of death (Item 23a	(Type, Pr	rint) D. PINDSE	M SINGP	30	c-10	MD	2	9715
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 23, Kathleen Anne Willett May 2005 3:55 pm /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country)
Jan. 16, 1925 Massachusetts If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months 1 □ M 2 C F 032-14-3921 80 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-1 show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2√€ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3433 S. Leisure World Blvd, Apt. 1A 20906 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No
If Yes, Give 1945 – 46
Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes Ž☐ No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Coughlin Helen Lynch ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Willett/ Son 4033 Lomar Drive, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 26. cemetery, crematory or other place) May 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signature uneral Service Licensee Francisc Address Coffilins Funeral Home Inc. 500 University Blvd, W, Silver Spring, Md 20901 23a. Part 1. Enter the disease, or cordinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in a cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Bilateral Cerebrovascular Accidents Month Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown cete has been signer, page 2 should be d Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificete To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🖾 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) May 26, 2005 D42452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) . Registrar's Signature State 26 Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death o5 PM **Physician** 4:00 LIF TOW SON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Hospita chestertown river If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day, Y Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 M 2 F Months 219-56-8222 53 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic everage. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State nester-town 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Roosevelt 316 2/620 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) aborer Johnson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manfield Wilson Anna Brooks Horace Gertrude 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bd Worton, MD Westhill Gertrude Janes (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Worton, MD 5130105 4 ☐ Donation 5 ☐ Other (Specify) Union United Church Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Butlertown MD Bennie Smith Funeral Home mnie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PULMONARY EDEMA Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): CHRONIC RENAL FAILURG Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner HYPERTENSION Due to (or as a conse uence of) Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ပ 1 ☐ Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗀 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760 P.O. the Š signed b Records. certificate has Division of Vital this After Hospital or Attending To the Hospital or Attendir within 24 hours after death. To the Funeral Director; At

> State Registrar

DHMH 17 Rev 1/200

(Check only one)

29b. Signature and title of

31. Date filed (Month, Day, Year)

rtifier

MAY 2 7 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Jennifer Delarosa, 6601 Church Hill Rd, Suite 200, Chestertown, MD

29c. License number

H0062423

29d. Date signed (Manth, Day, Year)

05

DHMH 17 Rev 1/2001

Registrar

		-	For State Registrar	State	of Marylar		artmen rtificat			and M	lental Hy	giene	とせじち	19541
	Physicia	an	1. Decedent's Name (First, Middle, La RUTH E. WITT	st)							2. Date of De Month MAY	Day	2005 Year	3. Time of Death 1:55A M
	/Medic Examin		4a. Facility Name (If not institution, gir	e street and nu	ımbər)		4b. City,	Town, or	Location o	of Death	THAT I		County of Death	1.55A
			ST VINCENT de P				FR If Under	OSTBU	JRG If Under:	24 Hrs	0.000.700		ALLEGANY	/C++
H	Funeral Director		217 10 4215	Gex 1 □ M 2/CXF	7. Age (In yrs. 96	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D. 10-8-	1908	9. Birth Cou MD	place (State or Foreign ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	e Mary Ba-f sh tiffed	ctor	MD Allega	ry	Fr	ostburg								1 Yes 2 No
	with th	Funeral Director	10e. Street and Number 48 Tarn Terrace				10f. Zip	Code 5 3 2					izen of What Cou	ntry?
	death ms 23	nerai	11. Marital Status		cedent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spi	ecify Yes or Ne Rican, etc.)	us/	14. Race - Ameri Black, White	
9	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Medical Exacities and be notified at	by Fur	1 Never Married 2 Married	Armed F 1 Tes If Yes, G Year or	2 V No	i	ii 1es, spei 1 ☐ Yes		Specify:	i, i deno	riican, etc.)			hite
21215-0036	tural,	ed b	3 ₩ Widowed 4 □ Divorced 15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ition			16b. K	ind of Business/Ir	
215	thin 72 e. ian "na	Completed	(Specify only highest gi) (1-4or 5+)	(Give	kind of wo DO NOT u	rk done a se retired,	luring mosi)	t of work	ing			
N	filed wi Hygien Sthar th ent, Ille		8 17. Father's Name (First, Middle, Las	*)		Text	tile	vorke		er's Name	(First, Middle		rufactur Sumame)	cng
and	lid be f lental } kad ol	To Be	John Patrick Wi) Cook		•	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat, or Itams 23a or 28a-1 show amy injury or other traumatic event, Ita Medical Examinet must be notified at ance.		19a. Informant's Nama/Relationship					•					or Town, State, Zi	
	1 and Health Sem 27		Harold F. Porte 20a. Method of Disposition	i, gran		Place of Dispo cemetery, crei	Cumi	ne of	ind H	ighw	ay, Mei Date	20c. Lo	date, PA	15552 own, State
altimore,	Pages nent of h ant: If its ury or o		1 Burial 2 Demation 3 in 4 □ Demation 5 □ Other (Spec							5 - 23	-2005	wel	lersbur	. PA
	permit. Departminimportal		21. Signature Funeral Service Lice	100		22	2. Name ar	d Addres	s of Facilit	У			-	
m T	#0 = # 3		23a. Part. Enter the disease, or cor shock, or heart failure. List only	inlications that	caused the dea								z, Hyndma	Approximate
	rnysician		Immediate Cause (Final	one cause on	each line.	made (Pard	ion	uso B	ett	ad			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	Ische (or as a conse	quence of):			0.0		J			
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conse	quence of):	-							
	cuted id ansit	Examiner	cause. Enter Underlying Cause Observed or Injury that initiated events	С.										
8760,	cate be executed physician and the burial-transit	i Exa	resulting in death) Last	Due to	o (or as a conse	quence of):								
687	ficate t physic	edicai		d				11:				- 1		
ŏ	leath certific attending p	M/ue	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		⊒Ectopic p	regnancy					23d. Date of deliv	
O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		nant at time of		Other (sp					- 33	Month	Day Year
۵.	uires that the signed by Id be detacted	by Ph	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	inderlying o	ause give	en in Part I		23e. Did	tobacco (use contribute to	the cause of death?
Records,	w requires been sign should be		Aortic St Chronic	cuoses		17.0			0-	-		/	No 3□Pro	bably 4 □Unknown
Sec Sec	e taw r has be je 2 sh	Completed	- Coronic (Melin	e Put	mon		770	sea —	24a. Was	s an opsy ormed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
Vital F		e Co	25. Was case referred to medical						26 Place	of Deat	1 ☐ Yes	2 X No	1 ☐ Yes	2 X No
	Physician: this certific al director,	To B	examiner? 1 □ Yes 25€ No	Hospital: 1	Inpatient 2	□ ER/Outpatie	nt 3 🗆 D0	Othe	400			-	6 □Other (Speci	(h)
o uc	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	(Mo	of Injury onth, Day Year)	28b. Time o Injury	of :	28c. Injury Work	/at <br Yes 2□	- 1	28d. Describe	how inju	ry occurred	
Division of	Attending Physician: sr death. ector: After this certific. by the funeral director.	ertification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Plac	ce of Injury - At I	home, farm, st				-	28f. Location City or To		nd Number or Rur	al Route Number,
ā	urs after ral Dir	O							- 77					
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Ext one)	miner: On the and ma	basis of examir nner stated.) and manner as : d place, and due !	
	To the To the Comp	Ň	29b. Signature and title of certifier	1. Chot	and'		29	c. License	number	53		29d. Da	ite signed (Month,	Day, Year)
!	i, y	8	30. Name and address of person wh	completed ca	use of death (Ite	em 23a) (Type,	Print)						RLANI	
		oto	HABIB C	tetan 1	Registrar's Sign		VNS	LVA	+/\///	1101	,			-,
	Sta Regist	ate rar	MAY 2 0)	100		Coul	2						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Robert G. Webster May 9, 2005 7:55PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Manor Care Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 17, 1918 9. Birthplace (State or Foreign Country) Virginia 6. Sex 1 → M 2 ☐ F 7. Age (In yrs. last birthday) Months Davs Hours 577-28-0382 86 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XYes 2 □ No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3909 Oliver Street 20815 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No1943- Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify Specify: White Yes Give 3 Widowed 4 Divorced 1960 Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John G. Webster Jessie Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie J. Webster / Spouse 3909 Oliver Street Chevy Chase MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State June 30 Arlington National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2005 Arlington, 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Se Licensee 5130 Wisconsin Ave. NW Washington DC 20016 23a. Part1. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Metastatic Bone Cancer Due to (or as a consequence of): Unknown Primary Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). H/O Cancer Bladder Due to (or as a consequence of): H/O Mouth Cancer 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏋 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 No 1 ☐ Yes 2 1 No 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

and

attending physician

Physician

Examiner

Funeral Director

Completed by

Be ဥ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show any Injury or other traumatic event, if the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0020

/Medical

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היינית כן נוכן ימונים בהיינים להיינים, אמצעל בי טולימים כל בסתמסוכם וכן כמל מס נוכן אמונים בחומן בחומן.	Certification: To Be Completed by Physiclan/Medical Examine
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or Attending Physicien: The law requires that the death certificate be executed after death.

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 Tyes 2 □ No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0054566 5/10/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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To the Hospital within 24 hours a To the Funerel (

State Registrar

31. Date filed (N

			For State Registrar	State of Maryland / Depa	irtment of Hea		tal Hygiene	20115	19543
	Physici	an	1. Decedent's Name (First, Middle, Last) Jean C. Williams				Date of Death Month Day	/ Year	. Time of Death 11:43 P M
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Loc		4c.	County of Death	
	Funeral Director		Laurel Regional I 5. Social Security Number 220-54-1626 Usual Residence of Decedent		Laurel If Under 1 Year If Months Days F	lours Min. (Date of Birth Month, Day, Year)	1020	erge's State or Foreign Jersey
e, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other treumetic svant, the Medical Examinar must be ricitlised at once.	To Be Completed by Funeral Director	10e. Street and Number 1131 University	Blvd, West, Apt. 21 12. Was Decedent Ever in U.S. Armed Forces? 1	Iver Sprin 10f. Zip Code 5 20 Nas Decedent of Hisparity Specify Cuban, March 20 No Statem's Usual Occupation kind of work done during DO NOT use retired) er Worked 18 19 Address (Street and O Nebel Station (Name of	9902 anic Origin? (Specify Mexican, Puerto Rica Specify: In mg most of working I. Mother's Name (Fite Edna	Yes or No- in, etc.) 16b. K Inst. Middle, Maiden Miller Suite Number, City of kville, I	izen of What Country? USA 14. Race - American I Black, White, etc. Specify: White ind of Business/Indust N/A Sumame)	ndian, e ry de)
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or otl		20a. Method of Disposition 1 \(\mathbb{T}\) Surial 2 \(\text{Cremation} \) 3 \(\mathbb{R}\) 4 \(\mathbb{D}\) Donation 5 \(\mathbb{D}\) Other (Specify) 21. Signature of Funeral Service License \(\mathbb{Q}\) Keu STULe	emoval from State George Wash Park	natory or other place) ington Memori	ial May 2 2005 Of Facility Collins F	7, Para uneral Ho	amus, New S	Jersey
8760,	Physician / Medical Examiner physician and	dical Examiner	23a. Padd. Enter the disease, or compil shock, or hearf failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Sepsis Due to (or as a consequence of):	er the mode of dying, s	such as cardiac or re-	spiratory arrest,	Int	proximate erval Batween set and Death
.O. Box 6	the death certific y the attending p iched for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	W5162		23d. Date of delivery Month Day	y Year
ords, P	law requires that as been signed b 2 should be deta		Part II. Other significant conditions cor Urosepsis, Hypot	ntributing to death but not resulting in the untroidism	nderlying cause given ii	n Part I.	23e. Did tobacco	Se contribute to the c	ause of death? 4 🖔 Unknown
Vital Records,	The ate h page	Completed					24a. Was an autopsy performed? 1 ☐ Yes 21% No	death?	etion of cause of
V:E	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Ansnital:		6. Place of Death (C			
of	ng Phys ter this neral dii	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	fospital: 1 Napatient 2 Napatient 2 R/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	4 Nursing Home 28d. 2 No	5 Residence Describe how injur		
Division	el or Attandir s after death. af Director; Al	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		Location (Street ar City or Town, State	od Number or Rural Ro)	oute Number,
	To tha Hospitel or At within 24 hours after or To tha Funaral Direct completely filled in by	edical (sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.					
)	To that within 24 To that complete	M	29b. Signature and title of certifier Source Market State of the sta	D. Attending.	29c. License nu	umber 42580		te signed (Month, Day May 20, 20	
_			30. Name and address of person who co Paramut Singh A		Print) napolis Rd	, #13, Bla	adensburg	, MD 20710)
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 5 200	2. Registrar's Signature	E)				

Jean Weltams, Dons 4-23-1930.

			1- State of Maryland / Depart Registrar Certifi	ment of Health and Micate of Death	fental Hygier	A CO CO CO	1001
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Louise Wilson		2. Date of Death Month	Day Year 2005	3. Time of Death
	Examin		Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	b. City, Town, or Location of Death Laurel F Under 1 Year If Under 24 Hrs.		4c. County of Death Prince G 9. Birth	eorge s
	Director	or	578-54-1394 1□ M 2★F 64 Yrs. M Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locate 10b. Md Prince George Bowie	lonths Days Hours Min.	01/03/4	11 Ge	orgia 10d. Inside City Limits 1X Yes 2 \(\) No
	h with the M 23a or 28a-f at be polifi	al Director	10e. Street and Number 6516 Homestate Drive (South)	10f. Zip Code 20720	10g.	Citizen of What Cou	ntry?
920	72 hours after death with the Maryland natural', or flams 23a or 28a-f show Jical Examination must be rediffed at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	d within 72 ho jiene. r than "natur the Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent (Give kin life. DO Homen	t's Usual Occupation d of work done during most of work NOT use ratired) naker	ing 16b	. Kind of Business/Ir	dustry
yland ?	2 should be filed withir and Mental Hygiene. is marked other than aumatic avant, I'm M.	To Be C	17. Father's Name (First, Middle, Last) Loyed Butler		e (First, Middle, Maid	all	Codel
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or flams 23a or 28a-f show any injury or other treumatic avant, the Modeal Examinar must be rediffed at one.		Monique Wilson Daughter 6516 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Homestate Dr on (Name of ory or other place) Memorial 5/2	(S) Bowi Date 200 8/05 I	e, Md 20 Location - City or To Landover	0720 own, State
Ball	permit. Depart Import any inj		23a. Part1. Enter the disease, or complications that caused the death. Do not enter t	ame and Address of Facility 1ead Funeral H 732 Georgia Av he mode of dying, such as cardiac	e NW Wa		Service n,DC 2001 Approximate Interval Between
8760,	And in the primary transit the burial-transit the b	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last a. Brudyarrhythmia Due to (or as a consequence of): Myocardial Inf Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Right Lower Lok	Tarction			1 day 1 day 1 day
.O. Box 68	aath certifii attending p for use as	Completed by Physiclan/Med		stopic pregnancy ther (specify)		23d. Date of deliv Month	ery Day Year
Δ.	w requires that the deben signed by the should be detached	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the under Diabetes Mellitus	ortying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death? bably 4欠Unknown
of Vital Records,		a	Stroke Hypertention 25. Was case referred to medical	26. Place of Deat	24a. Was an autopsy performed 1 Yes 2 X	? prior to co	opsy findings available impletion of cause of
Division of V	Attending Phride death sector: After the by the fineral	Cerification: To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	28c. Injury at Work? M 1 \sum Yes 2 \sum No	28d. Describe how in City or Town, Si	njury occurred t and Number or Run	
۵	To the Hospital or Attentivitin 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death or continuous and manner stated.	ocurred at the time, date and place, tigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier Cal vage State Cal vage State Cal vage State Stat	Dartit		Date signed (Month,	Day, Year)
•	Sta Regist		Padmaja S. Udapi, MD 7350 Van Du 31. Date filed (Month, Day, Year) 22. Registrar's Signature MAY 2 5 2005	sen Road, Suit	e#380 La	urel,Md	20707

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** MYUNG 5:17 P.M. YONG 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HUWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 79 522.35.7013 Director Dec. 8, 1925 Korea Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Anne Arundel Director Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8217 Autumn Lake Court 21144 Korea 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Services 12th Janitor

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or items 23a or 28e-f ehow any injury operater treumatic event, it is the significant interpretation ones.

Be

17. Father's Name (First, Middle, Last)

Yong Kum Yong

19a. Informant's Name/Relationship (Type, Print)

Im Keun Lim/Daughter

Physician /Medical **Examiner**

burial-transit

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician:

	Im Keun Lim/Daugh	iter	6037 Weel	kend Way,	Colum	bia, MD	21044	
	20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Removal from State	Place of Disposition (Naccemetery, crematory or rbeck Mem.	other place)	5/26/2		Location - City or	
	21. Signature of Funeral Service Licens		22. Name a	nd Address of Fac -RINALDI	FUNERA	L HOME.	INC.	ng, MD 20904
	23a. Part1. Enter the disk se, or comp shock, or head the List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the deat one cause on each line. a	th. Do not enter the mo					Approximate Interval Between Onset and Death HOMRS
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PNEUP Due to (or as a conseq	quence of):					Hours
edical Ex	1930ming in deality cast	Due to (or as a conseq	quence of):					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	al death 3 □Ectopic p				23d. Date of de Month	livery Day Year
ted by P	Part II. Other significant conditions co	entributing to death but not res	sulting in the underlying	cause given in Par	t I.	\ .		o the cause of death? robably 4 □Unknown
Comple	0'					24a. Was an autopsy performed? 1 ☐ Yes 2,20 N	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?					Check only one)		
မ	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 D	OA Other: 4 1	Nursing Home	5 🖺 Residence	6 Other (Spe	cify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 [280	I. Describe how in	ury occurred	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto (y)	ry, office	28f.	Location (Street and City or Town, Sta	and Number or Rite)	ural Route Number,
Medical	(Check only 2 Medical Exami	rsician: To the best of my kno iner: On the basis of examina and manner stated.	ation and/or investigation	n, in my opinion, de	eath occurred	at the time, date a	nd place, and due	s stated. s to the cause(s)
Σ	29b. Signature and title of certifier MD, 30. Name and andress of person who certifier 7350 Grz Ce	FCCP	29	D 368	45	29d. D	ate signed (Mont	h, Day, Year) , 2005 FCCP
	30. Name and a toress of person who o	Impleted cause of death (Item	n 23a) (Type, Print) /	1.A1-Ct	+1 NC	1044 1044	, UMD,	FCCP

18. Mother's Name (First, Middle, Maiden Surname)

Choon Ran Kim

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

26

32 Registrar's Signature

			For State Registrar	-	epartment of Health and Certificate of Death	Mental Hygie	211115	19546
	Physicia		1. Decedent's Name (First, Middle, Last) Richard Wyli	e Andrews	-	2. Date of Death Month	Pay OS Year	3. Time of Death
	/Medic Examin	100	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of De	ath MD	4c. County of Death	
- - - - - - -	Funeral Director		5. Social Security Number 6. Sex 1227 - 50 - 338 9	M 2□F 7. Age (In yrs. last birtho	Months Days Hours M		9. Birth	place (State or Foreign
	laryland show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	er Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23s or 28a-f show privet be notified at	Direct	10e. Street and Number 1	Thee)	10f. Zip Code	10g.	Citizen of What Cou	ntry?
92	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Itams 23s or 28s-f show other than "natural", or Itams 23s or 28s-f show event, the Medical Ever it are mail the mullifled a	y Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 X ves 2 \(\subseteq \text{No} \) 1 Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White	
21215-0036	within 72 hours ene. than "natural" na Neulcal Ev	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	reation 16a. D (6a. D (7a) (7a) (7a) (7a) (7a) (7a) (7a) (7a)	ecedent's Usual Occupation Give kind of work done during most of v fe. DO NOT use setired)	vorking 16b	. Kind of Business/Ir	ndustry
	ould be filed with Mental Hygiene arked othar tha atic evant, the	Be	17 Father's Name (First, Middle, Last)	5+ Ke	Search Anal	Ame (First, Middle, Mail	NS 4 den Sumame)	-4
Maryland	2 sho and is m	10	19a. Informant's Name/Relationship (Ty)	19b. N 19b. N 19b. N 19b. N	Mailing Address (Street and Number of	Rural Route Number, Ci	ity or Town, State, Zi	Q1207
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	cometen	isposition (Name of crematory or other place)	Date 200	Location - City or T	own, State
Baltir	permit. Page Department of Important: If any injury or once.		21. Synaure Fureral Service Licens		22. Vine and Address OF Face 7	eine Funer	alstown	, MD 21133
10	Pnysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do no le cause on each line.	t enter the mode of dying, such as card		9 400	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of)	litu	win argu	Lead	14 yrs
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of				
9	eath certificate attending phys I for use as the	/Medical	IF FEMALE: 2	3c. If yes, outcome of pregnancy			23d. Date of deliv	100
.O. Box	at the death of the by the attendached for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		Month Month	Day Year
Φ.	quires Ihat i n signed by uld be deta	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to	the cause of death?
Records,		Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Othor	Death (Check only one)		
of	_ = -	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	2 □ ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir	ne of 28c. Injury at	Home 5 Residence 28d. Describe how i		(v)
Division	_ 0 = _	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	al Route Number,
	To the Hospital of within 24 hours afford the Funeral Discompletely filled in	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sicien: To the best of my knowledge, ner: On the basis of examination and/and manner stated.	death occurred at the time, date and pla or investigation, in my opinion, death oc	ace, and due to the caus ccurred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier	in,	29c. License number		Date signed (Month)	
jī			30. Name and address of person who co	mpleted cause of death (Item 23a) (T 4 D, 5601 Local	ype, Print) 1 RAVEN BLVD B	SALTO. MD	21239	,
	Sta Regist		31. Date filed (Month, Day, Year) 2005	32. Registrar's Signature	RAVEN BLUD B			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of Mary	•	artment of He			200	in I proposed a
			State Registrar 1. Decedent's Name (First, Middle, Last)		Ce	Tillicale of D	eaur	2. Date of Dea	Reg. No. C. U []	3. Time of Death
	Physicia	an	WILLIAM	McKI	NTEY	ARNO	LD JR.	June	Day Year 4. 2005	
	/Medic Examin		4a. Facility Name (If not institution, give st		71-11-1	4b. City, Town, or L		Julio	4c. County of De	
	LXaiiiii	Ŭ.	Woodlands Assi	sted Liv	ing	Mide	dle Riv	rer		imore
٠.	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign country)
	Director		218-03-2391 1M2 Usual Residence of Decedent	W ZUF	84 Yrs.			10/28/	1920 D	laryland
	land		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Mary -1 sh	ţo	MD. Harfo	ord		Jar	rettsvi	lle		1 ☐ Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
	23a c		4036 Old Fede				21084			States
	d within 72 hours after death with the Maryland Jiene. r then "naturel", or Items 23a or 28e-f show the Medical Epaini act must be trollified at	Funerai	11. Wantar Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 □ No If Yes, Give Year or Dates:	W II	1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	72 hou nature		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupat	ion	ine	16b. Kind of Busines	s/Industry
215	within 7, ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	ming most of work	uig		
7	e filed with It Hygiene. other ther vent, the N	Co	12	0	Bloc	ck Opera		o /First Middle	Rail Maiden Sumame)	road
and	ould be fil Mental H arked ott atic even	Be	17. Father's Name (First, Middle, Last)	Winlow A	mnold 6			_		otter
Maryland	12 should be filed h and Mental Hyg 7 is marked othe traumatic event,	은	William Mo	Kinley A			Clara	J eY	r, City or Town, State,	
Z			William M. Arno			0 Cox R				Md. 21084
ē,	f Health item 27 i	1 8	20a. Method of Disposition	2	Ob. Place of Disp			Date	20c. Location - City of	
E	Page nent o int: If		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)			sville C	1	7/2005	Jarretts	ville, Md.
Baltimore,	permit. Pages: Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service License			2. Name and Address			ville, N	
<u>m</u>	20 E 2 A	0 0	11. Jakerekt	m rung.		E.G. Ku	rts & S	son Fur	neral Hom	e. P.A.
		S2	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line	death. Do not en	ter the mode of dying,	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			c Cardi	0-145Cm	on do	vsere-	cur Known
	/Medical Examiner		1	Due to (or as a co	ensequence of):					
		ē	Sequentially list conditions, b	Oue to (or as a co	neaquance of):					
H	outed id	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
0,	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as a co	ensequence of):					
8760,	ate be	dicai	d							1,00
9	eath certific attending p I for use as	a a	IF FEMALE:	3c. If yes, outcome of p	regnancy				23d. Date of d	eliven
Box	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 □ 4 □ Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
P.O.	that the de led by the dediached	nysi	1 Yes 2 No 9 Unknown	9□ Unknown						
	The law requires that the death certifinite has been signed by the attending I page 2 should be detached for use as	by Pl	Part II. Other significant conditions con	tributing to death but n	Λ ι		n in Part I.	<u></u>		to the cause of death?
Vital Records,	w require been sig should b	ed	Renot Je	rime,	Hou	read	Demi	1 1 1	/es 2 □ No 3 □ I	Probably 4 Hunknown
ecc	e law re has be je 2 sh	Completed	,					24a. Was autop	sv prior to	autopsy findings available ocompletion of cause of
H		Com							rmed? death?	s 214No
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Other	26. Place of Dear			Lounked
of	S S	10	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	int 3 DOA	4 Nursing H		dence 6 Mother (Sp now injury occurred	ecify) H
O	ding Ph h. After th funeral	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	Work'	es 2 ☐ No			
Division	Atten r dec ector	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	- At home, farm, s	treet, factory, office		28f. Location (S City or Tow	Street and Number or i	Rural Route Number,
ā	s after s afte	Certification:	4 Homicide	building, etc. (5	эрвс <i>ну)</i>			Only or Ton	vii, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier 1 Certifying Phys	sician: To the best of m	amination and/or i	th occurred at the time	e, date and place, inion, death occur	and due to the cred at the time.	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	the H in 24 the F nplete	dedi	one)	and manner stated						
	Viti Con	Σ	29b. Signature and little of certifier	1-D .		D-	3875	4	06-09	-2-005
7			30. Name and address of person who co	moleted cause of death	/Item 23a\ /Tura	Print)		1	4.5	
	121		MALIKA WAS		709.	BAST BA	en B	LUD	· IMD	-21221
_		ate	31. Date filed (Month, Day, Year)	32 Registrar's	Signature					

		•	1 - State Registrer		artment of Health and N rtificate of Death		ne No.2005	19548
	Physici		1. Decedent's Name (First, Middle, Last) Mustafa	Abdulla	h-Aleem	2. Date of Death Month JUNE	7, 2005	3. Time of Death 7:52P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and UNIVERSITY HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 216-04-2896	7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	ar) Coun	ace (State or Foreign try) 1D
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L			10	Od. Inside City Limits
	th the Maryland or 28a-1 show is natified at	Director	MD NA 10e. Street and Number	Baltimo	10f. Zip Code	10g.	Citizen of What Coun	
(0	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Exertinet County of the Countried at	Funeral	1 X Never Married 2 Married 1 Y	es 2 X No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	an Indian,
21215-0036	72 hours a "natural", o	þ	3 Widowed 4 Divorced If Yes 3 Solution 15. Decedent's Education (Specify only highest grade completed)	Give and a second of the secon	1 ☐ Yes M☐ No Specify: adent's Usual Occupation be kind of work done during most of work DO NOT use retired)	king 16b	Specify: B]	Lack
	within ane. than "	Completed		e (1-4or 5+)	be Technical		Jiffy Luk	oe
Maryland	s 1 and 2 should be filed f Health and Mental Hygis itam 27 ia marked othar othar traumatic event, II	To Be	Mustafa Abdullah-Al 19a. Informant's Name/Relationship (Type, Print)		Sandra I	Horton		Code)
	ges 1 and 2 s t of Health an If itam 27 ia I or othar trau		Sandra Horton Babat 20a. Method of Disposition	unde 4608	Parkton Street	t, Baltin		21229
altimore,	Page: nent o ant: If ury or		N Burial 2 ☐ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	King Me	emorial Park 6/9	9/05 Ra	andallsto	own, Md
Ba	permit. Departm Importa any inju		23a. Part 1. Ehter the disease, or complications	mes 4	22. Name and Address of Facility Iarch F/H West I300 Wabash Ave Item the mode of dving, such as cardiac		ore, Md	21215 Approximate
	Fnysician /Medical		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	inshot Wol	unds (2) to hea	0.27		Interval Between Onset and Death
	Examiner	je.	Sequentially list conditions b.	to (or as a consequence of): to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due d	e to (or as a consequence of):				
P.O. Box 68	aath certifi attending for use as	Physiclan/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
	juires that the d n signed by the ild be detached	by	Part II. Other significent conditions contributing	to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should	Completed				24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
f Vita	Physician: Th this certificate al director, paç	To Be (25. Was case referred to medical examiner? 1X Yes 2 No Hospital:	I ☐ Inpatient 2 ¥ ER/Outpation	Other	th <i>(Check only one)</i> ome 5 \(\text{Residence}	e 6 □Other (Specify	')
ion o	anding Phath. or: After the funeral	atlon:	1 Natural 5 Pending 2 Accident investigation 6	tate of Injury Month, Day Year) 7/05 17:05	Work?	July	shot	
Divis	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 Homicide	Place of Injury - At home, farm, suilding, etc. (Specify)	et	AVE, BRITH	more, pop	I Route Number, Che Walbing L
	he Hosp n 24 hou he Funei oletely fil	Medical	(Check only 3 Medical Exeminer: On t		ath occurred at the time, date and place investigation, in my opinion, death occu	rred at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier Zalizellal	Ale	29c. License number OCME	Л	Date signed (Month, INE 8, 2005)	5
	2		30. Name and address of person who completed	cause of death (Item 23a) (Type	111 Penn Street	Baltimore	e, Maryland	1 21201
	St Regist	ate rar		32. Registrar's Signature	1. Sparles			

		1	For State	State of Ma	aryland / Dep	artment of Heartificate of L			2005	1951.9
			1. Decedent's Name (First, Mic	die, Last)		a contract of L	Jean	2. Date of Death	g. Nó. UUU	3. Time of Death
	Physicia	in		ene.		Bake	-R	June	Day Year	17:14M
	/Medic Examin		4a. Facility Name (If not institut			4b. City, Town, or	Location of Death	V (X,)	4c. County of Dea	
	Examin	9.	The John	s Hupkins	- Hospitai	Balti	more	City	NA	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, 2-12-	Year) 9. Bir	thplace (State or Foreign
	Director		216-50-3739	TOW ZAP	59 Yrs.			2-12-	-46	Va.
	and and	-	Usual Residence of Decedent 10a. State 10b. Cour	ty	10c. City, Town or I	ocation				10d. Inside City Limits
	Many -1 eh	ţ	Mđ.	NA	Balti	.more				1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	-		10f. Zip Code		10	g. Citizen of What Co	ountry?
	th with	aiD	1515 Holbro	ok Street		2120	02		USA	
	4 within 72 hours after death with the Maryland liene. 14 han - natural; or Items 23a or 28a-1 ehow 14 a Medical Evant act must be notified at	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	or It	by Fu	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	If Yes, Give 43	No	1 ☐ Yes 2√2 No	Specify:		Specify:	lack
21215-0036	hour tural			ent's Education	16a. Dec	edent's Usual Occupa	ation		16b. Kind of Business	
15	within 72 ene. then "nei	Completed		hest grade completed)	(Giv	e kind of work done of DO NOT use retired,	during most of work	ing		
212	filed within I Hygiene. other then	E	12th grade	College (1-40)	En	vironmento	al Servic	es	St. Raphe	al Hosp.
P	be filed ital Hygid of other event, I	Bec	17. Father's Name (First, Midd	le, Last)			18. Mother's Nam	e (First, Middle, M		ker
yla		2	Preston		Johnson		Alice			
Maryland		4	19a. Informant's Name/Relation	inship <i>(Type, Print)</i> Son	19b. Ma 118	ling Address <i>(Street a</i> Prospect <i>I</i>	and Number of Hur Ave., Wes	t Haven,	City or Town, State,	eut 06516
	s 1 and 2 if Health item 27 i	1	Dana Pettaway 20a. Method of Disposition		20b. Place of Disp	position (Name of		-	20c. Location - City or	
Baltimore,				n 3 Removal from State		ematory or other place rmel Cem.	6-14	-05	Dundalk,	Mđ.
	音響音		21. Signature of Funeral Servi			22. Name and Addres			ore, Md.	21202
B	permit. Departi Import. any nj		1 Glade	- Ware	~	March F.H.	. East		. North Av	re.
			23a. Part1. Enter the disease, shock or heart failure. L	or complications that cause ist only one cause on each I	d the death. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
L.	Pnysician	0 3	Immediate Cause (Final disease or condition	CE	ILIC-EST	105	tom	7 FA	Lunes	Opset and Death
	/Medical Examiner		resulting in death)	Due to or as	a consequence of):		100	1		Vina - a
	Examine		Sequentially list conditions,	b	a consequence off.	myopk	4 CHN			1 GNANS 2
	pe tist	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Z Due to (or as	, ,	- en Sco	N			YEARS
	xecul and al-trar	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					()
8760,	icate be executed physician and s the burial-transit	dical E		d						
9	tificati g phy as the	ledi								19-11-11-11-11-11-11-11-11-11-11-11-11-1
Вох	leath certific attending p	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		B Ectopic pregnancy	,		23d. Date of de	livery Day Year
	that the death ned by the atter detached for u	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Other (specify)			Month	Day real
P.0	at the	Phy	Part II. Other significant cond	litions contributing to death I	but not reculting in the	underlying cause and	en in Part I	23e Did tol	nacco use contribute t	o the cause of death?
	w requires that been signed b should be deta	þ	Fait II. Other significant cont	mions contributing to again	out not resulting in the	underlying cause give	on arr wre.		s 2 No 3 P	- 1
Ö	v requ	etec						24a. Wasa	n 24h Were a	utoosy findings available
Records,	<u>a</u> % %	Completed						autops perform	y prior to ned? death?	utopsy findings available completion of cause of
Vital			25. Was case referred to med	ical			26 Place of Dea	1 ☐ Yes 2 th (Check only on	2 No 1 □ Ye.	s 2 No
>	Physician: r this certificanal director,	o Be	examiner? 1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2 ER/Outpat	ent 3 DOA Oth	0.00		ance 6 ☐Other (Spe	ecify)
1 of	ding Phys h. After this funeral di	n: T	27. Manner of Death Natural 5 Per	28a. Date of Inj (Month, D	ury 28b. Time		y at k?	28d. Describe ho	w injury occurred	
io	Attending r death. ector: After by the fune	atic	2 Accident	estigation		M 1 🗆	Yes 2 □No			
Division	or Att	Certification:		ald not be ermined 28e. Place of in building, e	ijury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	ural Route Number,
	pital o	Se	29a, Certifier 1X Certi	fying Physician: To the bes	t of my knowledge, de	ath occurred at the tin	ne date and place	and due to the ca	ause(s) and manner a	hetet 2
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only one)	cal Examiner: On the basis and manners	of examination and/or	investigation, in my o	pinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	Mithin Fo the	Me	29b. Signature and title of cer	tifier		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
	~		L. Mark	Colon	Ms	DC	25 00	468	6 10 05	
	3		30. Name and address of pers	son who completed cause of	death (Item 23a) (Typ	e, Print)	1.6.0		0	
0			HORACE LI	ANG The	Johns Hop	Kins Has	pi tal 600	N Walk	St Rutto	MD ZIZY?
		ate	31. Date filed (Month, Day, Young)	ear) . Regis	trar's Signature	we				
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DHMH 17 Rev 1/2001

		1	For And State Registrer	end Item	State of M 26 per ve	aryland rb.,G 8	/ Depa 44 06	irtment of l tificate of	ealth Death	and M	ental Hyg	giene Reg. No.	005		9550	
			1. Decedent's Name	(First, Middle, La	st)						2. Date of Dea	ath Day	Yea	ır	3. Time of Death	
	Physicia		MON	TE MU	RRAY	BL	um				06	05	_		6:22PM	1
	/Medic Examin	-			e street and number	-		4b. City, Town,	or Location	of Death			County of De		0	
			BACTIMERA	- RECHA	3. EXTEN	DED O	SAF		7100				BALTA	mi	RE CHT	4
	Funeral		5. Social Security N	umber 6. S	6ex 7. A	ge (In yrs. las	it birthday)	If Under 1 Year Months Days		r 24 Hrs. Min,	8. Date of Birt Month, Da FEB. 26	th y. Year) r	9. E	Birthpla Country	ce (State or Foreign	n
	Director		126-16-	-	X M 2□F	80	Yrs.		_l		FEB.26	,1925)		" NY	
	P .	- H	Usual Residence of 10a. State	Decedent 10b, County		10c. City	Town or Lo	cation						100	d. Inside City Limits	
	anyla shon		MD	N/A				IMORE							1 X Yes 2 □ No)
	Ne M	Director	10e. Street and Nur				DALI	10f. Zip Code				10a Citiz	zen of What	Countr	v?	_
	with t				ROAD #108			101. Zip 0000	212	ng	1				USA	
	s 23	era	11. Marital Status	ILLSTATT	12. Was Deceden	t Ever in U.S.	13. \	Was Decedent of	Hispanic O	rigin? (Spe	city Yes or No	- 1	14. Race - A	mericar	n Indian,	-
36	hin 72 hours after death with the Maryland B. a. naturel; or items 23a or 28e-f show Medical Examinative motified at	by Funeral		ied 2 X Married 4 □ Divorced	Armed Forces 1 [7] Yes 2 [If Yes, Give Year or Dates	No MMI		f Yes, specify Cub 1 ☐ Yes 2 🔀 No	oan, Mexica	an, Puerro I	Rican, etc.)		Black, W Specify:		c. WHITE	
21215-0036	2 hou atura			15. Decedent's E	ducation (16a. Dece	dent's Usual Occu kind of work done	pation	et of worki	na	16b. Kir	nd of Busine	ss/Indu	stry	
215	within 72 ene. than "na' he Medic	Completed		only highest grandary (0-12)	College (1-40)	5+)	lite.	DO NOT use retire	ad)	ISE OF WORKI	<i>'</i> 9		5.7.1.0		ED.T. 1.1. O	
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	be filed ital Hygi od other event, I	Be (17. Father's Name	(First, Middle, Last	")						(First, Middle,					
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an	2 sho and I is ma euma		19a. Informant's N		_			ng Address (Stree								
	# 2 ₹ 5		HELENE		IFE	1001 51		FALLSTA	FF RC		-					
Baltimore,	m O >-				Removal from Stat	e cei	netery, crei	sition (Name of matory or other pla NS CEMET)/2005		cation - City WINGS		LS, MD	
Balti	perrit. Page Department Important: if any njury or		21. Signature of Fi	uneral Service Lice	nseef			2. Name and Addr 900 REIS								
Ш			23a. Part1. Enter t	the disease, or con	nplications that caus one cause on each	ed the death.	Do not ent	er the mode of dy	ing, such a	s cardiac o	r respiratory a	rrest,		1	Approximate nterval Between	
	Pnysician		Immediate Cause disease or condition	(Final										(Onset and Death	
4	/Medical		resulting in death)	-	a. Due to (or a	as a conseque	ence of):	// //		,,_,,				d		
	Examiner		Sequentially list co	onditions	b. Ch	rinic	06.	THIN S structury	Pa	lmr	They	Disc	ne.	3		
	D .=	ner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	Due to (or a	as a conseque	ence of):									
	ecute ind frans	Examiner	Cause (Disease or that initiated event resulting in death)	s Injury	C	is a conseque	and of):							1		
50,	cate be executed physician and the burial-fransit		, and a second		Due to (or a	is a conseque	31100 017.									
8760,	at Se	dicai		•	d											_
9		/Me	IF FEMALE:		23c. If yes, outcon	ne of pregnan	cv						23d. Date of	deliver	v	
Вох	The law requires that the death certifica ate has been signed by the attending pt page 2 should be detached for use as I	by Physician/Me	23b. Was deceder in the past 12	2 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	□Ectopic pregnan □ Other (specify)	су				Month) Day Year	
	he de	ysic	1 ☐ Yes 2 9 ☐ Unknowr		9□ Unknown			,,, .								
P.0	res that t igned by be deta	h H	Part II. Other signi	ificant conditions	contributing to death	but not resul	ting in the u	inderlying cause g	iven in Par	t I.	23e. Did	tobacco u	ise contribut	e to the	cause of death?	
ds	uires sign ld be	q p	Fa	ILUNE 1	6 thrive						1 🗆	Yes 2	□No 3□] Proba	bly 4 🗹 Unknown	n
Records,	w requir been si should	Completed									24a. Was		24b. Were	autop	sy findings available	ie
Re	ne tan has ge 2	Ę.									auto	ormed3	death	to com 1? Yes 2	pletion of cause of	
a	n: Th ficate or, pa		25. Was case refe	erred to medical		. <u>-</u>			as Dia	ce of Death	1 Yes	2 No		195 4	2140	
Ę	Physician: this certificaral director, p	o Be	examiner?		Hospital:	Ment 2□F	R/Outpatie	nt 3□ DOA C	thor	/	me 5 Resi		6 ∏Other (S	Specify		
o ;	ding Physician: The lav h. Atter this certificate has funeral director, page 2	1: To	27. Manner of Dea		28a. Date of I	njury	28b. Time o				28d. Describe			, , ,		
on	ding th: : Afte	tior	1 Natural 2 Accident	5 Pending investigate		Day Year)	Injury		onk? ⊒Yes 2{	□No						
Division of Vital	i or Attending after death. Director: After I in by the fune	fica	3 🗌 Suicide	6 Could not determine	d 286. Place of	Injury - At hor	ne, farm, st	reet, factory, office	9		28f. Location (City or To	(Street an	d Number of	r Rural	Route Number,	
Ö	after Dire	Certification:	4 🗌 Homicide	_	building,	etc. (Specify,					Ony or 10	Wil, State	'/			
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)	1 ☐ Certifying F 2 ☐ Medical Exa	Physician: To the beaminer: On the basis and manner	of examinati	vledge, dea on and/or in	th occurred at the nvestigation, in my	time, date opinion, d	and place, eath occurr	and due to the ed at the time,	cause(s) , date and	and manne d place, and	r as sta due to	ited. the cause(s)	
_	ro the within To the	Me	29b. Signature an	d title of certifier	./ /			29c. Lice	nse numbe	r			te signed (M		Pay, Year)	
/	1		1	11	hah	40		Ds	273	9		6/	5/05	pet-		
(10.141		30. Name and add	dress of person wh	o completed cause of	of death (Item	23а) (Туре				,					
				ShAN	Lelia	3500	Lo	ch Rar	182	1310	1 B	2/to	mer	, 00	12/2/218	8
	St	ate	31. Date filed (Mo	nth, Day, Year)	32. Reg	strar's Signat	ure	w .							12/2/2	
		rar		UN 1 3 20	105	10	Ana	251								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0349 BAKER ALMA 6, 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE JOHNS HOPKINS BAYVIEW MERCHL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Days 1 ☐ M 2 1 戸 F Yrs. 83 160-20-6267 Oct. 5,1921 Pennsylvania Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 7319 Hughes Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 20 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify: Specify: 3√ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Russell Earl Keim 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7323 Hughes Avenue Edgemere, Maryland 21219 Mr. Richard Baker (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ° 4 □ Dopati 57 Other (Specify) Gardens of Faith Cem. 6/9/2005 Rosedale, Maryland ieral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature o 7922 wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION 4 DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

23a.

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat must be realised at

Physician/Medical Examiner burial-transit physi the b as use

for ģ signed to be det page certificate within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Completed by

Be

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Certification:

Medical

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

5 Pending investigation 6 Could not be determined

Hospital:

1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

(Check only one)

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

(Varil her, M.D.

RES-000

29d. Date signed (Month, Day, Year) JUNE 6, 2005

State

To the Hospital or Attending

David Lim, M.D. 31. Date filed (Month, Day, Year)

4940 Eastern Ave. 32. Registrar's Signature

Baltimore, Maryland

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Medical Ctr.

		1	For State Registrar		State of I	Marylan		artmen rtificate			and M		Reg. I	/	05	195	552
	Physicia		1. Decedent's Name (First, Middle, MAE	Last) BUCHANAN							2. Date of D Month JUNE		9, 200	rear	3. Time of E 5:16P.	
	/Medic Examin		4a. Facility Name (If n			er)		4b. City,	Town, or	Location o	of Death	JUNE		4c. County of	Death		
			UNIVERSITY			A //	da a da finale ada a d	BA If Under	LTIM	ORE	24 Hrs	C Data of D	db				Foreign
	Funeral Director		5. Social Security Nun 219–12–580		7. Sex 1 □ M 2 🖫 F	80	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D	ау, үөг	17)	Cou	place (State or ntry) to. Ci	
	pug *		Usual Residence of D			10c. Cit	y, Town or Lo	cation								10d. Inside City	y Limits
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	ith the	Direc	10e. Street and Numb	er				10f. Zip	Code 210	148			10g. (Citizen of Wh		ntry?	
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98	72 hours after death with the Maryland natural', or Items 23a or 28a-f show incal Examir er must be mulified at	Completed by Funeral Director	1 Never Married	_	If Yes, Give	₹ No		ifYes,spec 1 ☐ Yes		n, mexicar Specify:	i, Puerto	Hican, etc.)		Specify:	, White	White	
5-0036	2 hours atural', cal Ex	ted b	3 Widowed 4	5. Decedent's	Year or Date	98:	16a. Dece	dent's Usua	al Occupa	ation	A n.f		16b.	. Kind of Bus	iness/lr	ndustry	
21215	within 72 ene. than "na	npie	(Specify Elementary/Second	-	grade completed) College (1-4	or 5+)	life.	kind of word DO NOT us Manag	se retired	during mos ()	t or work	ng	We	estern	E16	ectric	
d 21	filed w Hygier othar tl	e Co	12 Grade 17. Father's Name (Fa	irst, Middle, L	ast)			1141142	,01	18. Mothe	er's Name	e (First, Middl					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene it the strain or Items 23e or 28e-f show item 27 is marked other then "natural", or Items 23e or 28e-f show other traumatic event, If a Marical Examiner must be natified at	To B	Robe	rt	Worde	n	,				На	ttie	Gla:	ser			
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	s 1 and 2 if Health item 27 other tra		20a. Method of Dispo	sition		20b. F	ZJII Place of Dispo cemetery, crei	sition (Nar	ne of	1		Date FI		ourg Location - C			
Baltimore,	Page ment c tant: If jury or		`4 □ Donation 5	Other (Sp		Mt	Paran		-	1	6/15			ndalls			
Ball	permit. Pages 1 and Department of Healti Important: If item 2; any injury or other once.		21. Signature of Fund	eral Service L	icensee			2. Name an LINE				1824 R Reiste				коаа 21136	
	*	(1)	23a. Part1. Enter the shock, or heart	disease, or of failure. List of	complications that cau	ised the deal										Approximate Interval Betw Onset and D	veen
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8760	ys e	licai			d												
Box 6	leath certificate attending phys I for use as the	/Med	IF FEMALE: 23b. Was decedent p	oregnant	23c. If yes, outco			7-						23d. Date	of defin	rery	
	requires that the death leen signed by the atter hould be detached for u	Physician/Me	in the past 12 m 1 Tyes 2 0	nonths?		h 2∏Feta nt at time of o m		□Ectopic pr □ Other (sp						Mont	th	Day Y	'ear
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rds,	w requires been sign should be	ed by										10] Yes	2 No 3	B □ Pro	bably 4 □U	Inknown
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f Vi	di si	To B	examiner? 1∑ Yes 2 □ N		Hospital: 1 🗆 Inj	oatient 2 🔯	ER/Outpatie			er: 4 🗆 Nu	ursing Ho	me 5 Re	sidence				
on of	ng After Ine		27. Manner of Death 1 Natural	5 Pending		Day Year)	28b. Time of Injury	P _M	28c. Injun Wor	yat k? Yes 2∐ X	No I	28d. Describe	now in	njury occurre	d and	erct ver	nive
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	To the within 2 To the complet	Me	29b. Signature and t	itle of certifier	4			29	c. Licens OCN	e number Œ				Date signed			
	X		* Hama	17 MH	who completed cause	of death (Ita	m 23a) (Type	Print)						NE 10,			
(30. Name and addre	LE. E	cuethau, m	().		111	Penr	1 Stre	eet	Baltin	ore	, Mary	ılar	d 21201	L
	Sta Regist		31. Date filed (Month		3 2005 32. Re	oistrar's Sign		6020									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 2005 9 10:31p M 6 Rosalie L. Beale /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Balto Joseph Richey House Date of Birth (Month, Day, Year) 3-25-1932 Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 212–28–6803 **Funeral** Months Hours 1 □ M 2 🕅 F Md 73 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b County 10a State or 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "netural", or Itama 23a or 28a-f ehov other traumatic event, It e Medical Examiner must be notified at Yes 2 No Directo Md N/A Balto 10g, Citizen of What Country? 10f Zin Code 10e. Street and Number 2017 W. Lexington Street 21223 USA Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: **Black** 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Service Elementary/Secondary (0-12) College (1-4or 5+) Accounts Payable N/A12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any liury or other traumatic event once. Be Charlotte Harris John Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 723 S. Woodington Road Balto, Md 21229 Douglas Robertson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 6/13/2005 Catonsville, Md Meto Crematory * 4 □ Donation 5 □ Other (Specify) March F/H West 22 Name and Address of Facility 21. Signature of Funeral Service Licenses 4300 Wabash Avenue Balto, Md 21215 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER I 50 PHAGUS Medastate Physician 5 MG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner principle of the state of the s Sequentially list conditions, if any, leading to infroduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner inding physician and use as the burial-transit thromho Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 1 Yes 2₽No Vital 26. Place of Death (Check or Ivrone) Other: 4 Nursing Home 5 residence 6 Bother (pecify) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ♠No P this 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

within 24 hours a To the Funeral C State Registrar

DHMH 17 Rev 1/2001

osa 11e

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

D.0601

29d. Date signed (Month, Dav. Year)

SUCC

ORIGINAL

Keerio MD

SUTAW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 0120 Joseph Merrill Brown Sr. 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saltmore 2 8. Date of Birth (Month, Day, Year) 11 15 23 If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Hours Min X□M 2□F Director 189-16-8072 81 Usual Residence of Decedent the Marytand 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner roust be notified at 1 Yes 2 □ No Director NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 Items 23a Terr. U.S.A. 2711 Chelsea Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Maryland 21215-0036 ō 1 ☐ Yes 🎾 No Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: Black "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Pastor Church 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Carrie Gassaway Joseph Leon Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tam 27 Kathryn Brown-Wife 2711 Chelsea Terr., Baltimore, Md 21216 othar t itam Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ŏ Department of Important: If any injury of once. 6/17/05 Garrison Forest Owings Mills, Md 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mutastatic DISCOR MENDUN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseduence of Examiner sician and burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 981 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Qunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA ð 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21215 re Ave., west 2401 jana Begistrans Signature Registrar

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Examin	ner	University of Ma	aryland Med	dical Cer	nter Bal	timore			40.0		
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н	Physici	an	1. Decedent's Name (First, Middle, Last)	2-111-	Date of Death Month D	ay Yeer 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Examin	er	Bon Secour	Baltimore		NIA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		216-84-8964 1□M 2□F 42 Yrs Usual Residence of Decedent		4/11/19	63 MD
	/land		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	e-fsh	ctor	MD NA Bult	imore		1 ☐¥65 2 ☐ No
	or 28	Oire	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	s 23e	rall	1025 Edmindson Ave	21223		USA
	ter de Items irer	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 ☐ Merried 1 ☐ Merried 1 ☐ Yes 2 ☐ Wo	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	hours after death with the Maryland turel', or Items 23e or 28e-f show at Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Ho Specify:		Specify: BIK
5-0	72 hc	Completed	(Specify only highest grade completed) (G	cedent's Usual Dccupation ive kind of work done during most of working	16b.	Kind of Business/Industry
2121	within ene. then "	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	Factory worker	$\cdot \mid \alpha$	De Can Company
	illed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	rst, Middle, Maide	on Sumame)
land	uld be Menta irked tric ev	To B	Norman fretLow	Jannie	Ann	Bennett
Maryl	2 sho and I is ma	6 8	17 UICHT ACT	ailing Address (Street and Number or Rural Ro		
- 15	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hyglene. tiem 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, I're Madical Examiner must be rediffised at		Sannic Ann Bennett 10= 20a. Method of Disposition 20b. Place of Dis	SEdmond Son Assposition (Name of Date		Location - City or Town, State
nor	e i i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, of	crematory or other place)		•
Baltimore	2 t t t 7		21. Signature of Funeral Service License	22. Name and Address of Facility 915)	Butto	Ned ZPite Batto
ä	Depar Depar Impo eny ir	i i	Vaugun & Line	Vaugno C Greene	- Fune	IN SER MD. 21229
П			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	r tachycards	a. 11) . / .
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8760,	cate be execut physician and the burial-trar		resulting in death) Last Due to (or as a consequence ले):	318		
687		edical	d			
Вох	death certifii e attending p id for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3□Ectopic pregnancy		23d. Date of delivery
O. B	0 0 0	Physician/Me		5 Other (specify)		Month Day Year
α.	requires that the de veen signed by the a hould be detached f	, Ph	Part II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	igr be	d by		, , ,	1 🗆 Yes	2 PNo 3 Probably 4 □Unknown
Record	> 40	Completed			24a. Was an	24b. Were autopsy findings available
Re	e ye	mo			autopsy performed?	prior to completion of cause of death?
Vital	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiper?	26. Place of Death (Cl		
of \	0 70	۲.	examiner? 1 Des 2 No PC Whospital: 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a, Date of Injury 28b. Time			6 □Other (Specify)
	Iding Ih. : After i funer	tlon	1 Matural 5 Pending (Month, Day Year) Injur 2 Accident investigation		Describe how inj	ary occurred
Division	of or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Location (Street a City or Town, Sta	and Number or Rural Route Number,
	rs after or real Director	Cert	Building, etc. (Specify)		Only of Town, Sta	
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral (edical	29a. Certifier (Check only one) 2□ Medical Exeminer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and r investigation, in my opinion, death occurred a	due to the cause(t the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
)) (figrawa)	D002522;	8 6	13/05
	27		30. Name and address of person who completed cause of death (Item 23a) (Type	Den secous	HOSA	Hal, Balt.
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3 2005 32. Registrar's Signature	Society	1	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician Αм Choon Keun Bae 2005 3:15 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Edgewater 165 Cardamon Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1**∑**M 2□ F Yrs 1933 Director APR. 28, 552-69-4669 Korea Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-1 show event, the Medical Exercited at 1 ☐ Yes 2 ☑ No Directo MD Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 165 Cardamon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Asian Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bakery Owner Bakery 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sun Jung Kim Neung Ha Bae 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 165 Cardamon Drive, Edgewater, MD 21037 Insung Bae - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6/10/2005 Marriottsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Grdns. 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Funeral Service License any 5555 Twin Knolls Road, Columbia, MD 21045 Approximate Interval Between unset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final lat **Physician** 455 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Day Year ō Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown à peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2U No 1 Yes 2, No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2€No 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Des ribe how injury occurred 28b. Time of Certification: After t 1 Natural Injury 2 🗌 No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) listed in by 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title completed cause of death (Item 23a) (Type, Print) Name and address of person 0 Ne 31. Date filed (Month, Day, Year) 32 An Strar's State

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	/Medic		James Edward	Brennan					Ju	ne	10		11:49 A M
	Examin		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, T	own, or L	ocation o	of Death		4c. Count		
			20 Birch Bark Co			Owing						imore	
	Funeral			3. Sex 7. 1 1 M 2 □ F	Age (In yrs. last birthda 50 Yrs.	Months		If Under 2 Hours	Min. 8. Da	ate of Birth fonth, Day,	Year)	9. Births	place (State or Foreign
	Director		165-38-5898	******	59 Yrs.				Sex	ot.26,	1945	Penn	sylvania
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re	is 1 and of Haalth itam 27 othar tr		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	2 Dameuel from St	20b. Place of Di cemetery,	sposition (Nam crematory or ot	e of her place))	Date		20c. Location	- City or To	own, State
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Division	of or Attence after death I Director:	Certification;	3 Suicide 6 Could n 4 Homicide determi	and 200. Place	of Injury - At home, farm g, etc. <i>(Specify)</i>	, street, factory	, office			City or Tow		ber or Hur	ral Route Number,
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		Registrar				Ce	rtificat	te of L	Death			Reg	. No.	005)	100	151
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			For State Registrar	Sta	ate of N	Marylar		artmen <i>rtificat</i>				lental Hyg	giene Reg. Nó.	200	5	19	562
	Physici	an	1. Decedent's Name (First, Midd									2. Date of Dea	Day	Y	eer		of Death
1	/Medic		Michael		trick		С	onway				June	<u> </u>	.005		4:15	5 A M
	Examir	er	4a. Facility Name (If not institution 7810 Clark R	-	<i>and numbe</i> Lot C				Town, or SSUD	Location of	of Death			County of I		lab	
	Funeral		5. Social Security Number	6. Sex			last birthday)	If Under	1 Year	If Under		8. Date of Birt	ħ		Birthp	lace (State	e or Foreign
	Director		218-88-4823	XX M 2	₽□ F	37	Yrs.	Months	Days	Hours	Min.	Aug. 9	y, Year) 196		Coun	land	
	pu *		Usual Residence of Decedent 10a. State 10b. County	,		10c Ci	ty, Town or Lo	nation							14	Od Incido	City Limits
	Aaryla I sho	ŏ		Arunde	1										''		es 2X No
	the N	Director	10e. Street and Number	Arunde	<u> </u>	MI	llersv	10f. Zip	Code				10g. Citi:	zen of Wha	at Coun	try?	
	d within 72 hours after death with the Maryland jene r than "natural", or Itams 23a or 28a-1 show Itte Madical Exantinari ust be indiffied at		1139 Dicus Mil	.1 Road					21	108				USA			
	ams 2	Funeral	11. Marital Status	12. W		nt Ever in U	J.S. 13.	Was Deced	dent of Hi	ispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)	. 1	14. Race Black, \			
36	or It	by Fu	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	. If '	⊒Yes 2X Yes, Give			1 ☐ Yes		Specify:		, , , , , , , , , , , , , , , , , , , ,	1	Specify:		nite	
Ö	hour tural			nt's Education	ear or Date:	s: 	16a Dece	dent's Usua	al Occupi	ation			16h Kir	nd of Busin	ess/loc	fustor	
215	within 72 ene. then "ne	plet	(Specify only highe	st grade com		N. 5.4.\	(Give	kind of wo DO NOT u	rk done d	durina mos	t of work	ring	100.74	14 01 04311	030/11/0	dony	
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pu	be filed tal Hygid d other evant,	Be	17. Father's Name (First, Middle,	Last)								e (First, Middle,		Sumame)			
ryla	2 should be and Mental Is marked of surmatic ev	10	Gerard Conway 19a. Informant's Name/Relation:	ship /Tupa Pr	rintl		10b Maili	a - Address	/Street			Ley Dieb al Route Numbe		Tour Ch	4n 7!-	On do)	
Maryland 21215-0036	s 1 and 2 should be filled f Health and Mental Hyg Item 27 Is markad othe othar traumatic evant,		Marianne Conwa		-							. Meade,				Code)	
	is 1 and 2 of Health a Item 27 is other tree		20a. Method of Disposition				Place of Disper	sition (Nar	ne of			Date		cation - Cit		wn, State	
E	Page nent o nrt: If		1 X Burial 2 □ Cremation `4 □ Donation 5 □ Other (\$		al from Sta	te	en Hav	•	•	1	5-9-2	2005	Gler	n Buri	nie.	MD	
Baltimore,	permit. Pages 'Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service	Light			2	Name an	d Addres	s of Facilit	hv						
	89789		170 9	. ~J~								Home, P. Annapo		MD 2	2140		
þ			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complication t only one cau	is that caus	sed the dea	th. Do not en							1		Approxima Interval Be Onset and	Between
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9 xc	death certific attending pl	ian/Me	IF FEMALE: 23b. Was decedent pregnant			ne of pregn							2	23d. Date o	f delive	rv	
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Rec	e lav has	mp										24a. Was autop		Drioi	r to con	sy finding npletion of	s available cause of
Vital	in: Th ificate or, pag	e Co	25. Was case referred to medica	al .						OC Blace	of Door		2□No	183	h? Yes	2 🗌 No	
Š	Physician: this certific rat director,	To B	examiner? 1 Yes 2 No	Hospita	al: 1 ☐ Inpa	atient 2	ER/Outpatie	nt 3 DO	Othe	25		me 5 Resid		XX ther (Specify	at s	scene
J Of			27. Manner of Death 1 □ Natural 5 □ Pendi	288	a. Date of it		28b. Time o		28c. Injury Work	at		28d. Describe h		occurred		0	beene
Sio	en or:	catio		igation (0-4-	05	4:03			Yes 2 🔼	No	seceas	-	stak			
Division	ē ji ji o	Certification:	4 Homicide determ		e. Place of building,	Injury - At h		1 - 100	1			28f. Location (S City or Tow	m, State)	7810	Cla	rk Rd.	.CotC58
П	spita ours naral fillec		29a. Certifier 1 ☐ Certifyi	ng Physician	: To the be	st of my kn	vid'S	h occurred		ne, date an		Homover and due to the					,
	To the Hos within 24 h To Iha Fur completely	edical	(Check only one) Medica	Examiner: C	n the basis nd manner	s of examina	ation and/or in	vestigation	, in my or	oinion, dea	th occur	red at the time, o	date and	place, and	due to	the cause	ı(s)
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•	d			Carro	X	/ - /			OCME	ı			Jun	e 5,	200	5	
4	7 ,		30. Name and address of person	who complet	A Cause o	of death (Ite	m 23a) (Type,		Pon	n Str	coat	Bo1+4-	00	M	-7	J 01	201
	Sta	ate				strar's Sign	ature		ren	n Str	.eet	Baltin	ore,	, Mary	уLar	ia 21.	ZUI
	Regist		31. Date filed (Month, Play, Tea) 4003	The Real	ARI A	ature	we									

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		-	For State Registrar	State of Maryland		ertificate of L			Reg. No		19563
H	Physicia	_	1. Decedent's Name (First, Middle, Last)	4		(0 0 0		/Mo		y Year	3. Time of Death
	/Medic Examin	al	Eleanor 4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, or	_		ne 10	c. County of Death	17007
	LAAIIIII		THE Johns HOPKI	us Hospit	AL	BAlti	MORE	E Cit	4		
	Funeral		5. Social Security Number 6. Sex 1 1	7. Age (In yrs. la	ast birthday Yrs.	Months Days	If Under 24 Hours	Min. 8. Dat	of Birth onth, Day, Year t. 2,19	9. Birthpla Countr 954 Mary1	ce (State or Foreign y)
	Director		Usual Residence of Decedent	30				sep	L. Z.13		
	arylan ahow d at	_	10a. State 10b. County		, Town or	ocation				10	d. Inside City Limits 1 ☐ Yes 2X No
	he Ma 28a-1 a	Director	MD Anne Aru	ndel F	Riva	10f. Zip Code			10a C	itizen of What Count	
	3a or	i Dir	3099 Sussex Place			,	1140		103.0	USA	,
	death	nera		2. Was Decedent Ever in U.S Armed Forces?	S. 13	. Was Decedent of Hi If Yes, specify Cuba		n? (Specify Ye Puerto Rican,	s or No- etc.)	14. Race - America Black, White, e	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow amy injury or other traumatic event. I'm Medical Expoir entrante notified at anone.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes Ž	Specify:		· i	Specify: Whi	
21215-0036	2 hour	ted t	15. Decedent's Educ	ation	16a. Dec	edent's Usual Occup	ation	- A	16b. I	Kind of Business/Indu	ıstry
215	thin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done of DO NOT use retired	during most o	or working			
2	iled wi tygien her th	Con	17. Father's Name (First, Middle, Last)	4	Musi	Teacher	18 Mother's	s Name /First	Ele Middle, Maide	mentary E	ducation
Maryland	d be fi	To Be	Emanuel Simpson						Abrahan	,	
ary	shoul and Ma s marl umati	F	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma	ling Address (Street					Code)
	and 2 ealth a n 27 is			Husband)		9 Sussex P					
lore	it of H it of H if iter or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	moval from State		position (Name of ematory or other place	-	Date		ocation - City or Tow	
Baltimore,	artmer artmer ortant injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			Gardens 22. Name and Addre:		/15/200	5 0	lney, Mar	yLand
Ba	Depar Impor any ir		13- g. Co			Hardesty	Funer	cal Hom	e, P.A.	s, MD 214	01
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death e cause on each line.	. Do not e	nter the mode of dyin	g, such as ca	ardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Interstit		Lung	Disco	. 50			15 years
	Examiner			Due to (or as a consequ	ience of):						-
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	ecuter and -trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):						
38760,	ficate be executed physician and is the burial-transit	aiE		220 10 (01 20 2 2011004							
_	tificate og phys as the	fedical									
Вох	attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregna 1 Live birth 2 Fetal	death 3	Ectopic pregnancy	,		i	23d. Date of deliver	y Day Year
P.O.	he deg	Physician/M	1 ☐ Yes 2 ⊠No 9 ☐ Unknown	4∏Pregnant at time of de 9☐Unknown	eath 5	□ Other (specify) _					4141
	law requires that the death certif as been signed by the attending 2 should be detached for use a	by Ph	Part II. Other significant conditions con	tributing to death but not resu	ulting in the	underlying cause giv	en in Part I.	23	e. Did tobacco	use contribute to the	cause of death?
rds	w require: been sig should b		Prevnomediusing	<u></u>				_	1 Tes	2 □ No 3 □ Proba	bly 4 Minknown
ecc	e law re has be je 2 sho	Completed						24	a. Was an autopsy performed?	prior to com	sy findings available pletion of cause of
al H	Th ate pag		_						Yes 2XN	death?	2□ No
Z.	ysician; T is certificat director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 1 Inpatient 2	FR/Qutpat	ent 3 DOA Oth		of Death (Checosing Home 5		6 ☐Other (Specify)	
l of	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur	of 28c. Injur	y at	9	escribe how inj		
sior	Attendin ar death. rector: Af by the fur	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2□N		antina (Ctanata	and Mumber on Direct	Courte Months of
Division of Vital Records,	- t - c	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		street, factory, office		ZBI. Co	ty or Town, Sta	und Number or Rural te)	Houte Number,
_	To the Hospital or within 24 hours after or the Funeral Direction of Completely filled in		29a. Certifier Certifying Phys	ician: To the best of my kno er: On the basis of examinat	wiedge, de	ath occurred at the tir	ne, date and	place, and du	e to the cause(s) and manner as sta	ited.
	the Ho in 24 the Fu	Medical	one)	and manner stated.	mon and/or			1 occurred at ti		ate signed (Month, D	
	The Co	~	29b. Signature and title of certifier	k : -		29c. Licens	e number Es-O	00		6/10/05	
1	0 1		30. Name and address of person who co	, (, (, (23a) (Typ		· > U			0, 701	
l	0		JOHN KOETHE N	D. JOHNS	140PK	ins HOSPITA	14 600	O WOLF	E STREET B	Actino RE	mo 21287
:	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 3 200	32 Registrar's Signa	ture	selle					

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 3. Time of Death **Physician** JUNE PHILIP CASCIO 8.10 A.M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore Co. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov 20, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 11X M 2 □ F Director 217-09-4895 83 Yrs. Baltiomre MD Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28e-f show The Medical Examiner must be notified at MD Baltimore Co. Reisterstown 1 ☐ Yes 2 XX Mo Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 120 Salony Dr. 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 42-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white ģ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other treumstic event Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Ticket machine repair horse racing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony V. Cascio Rose Zanti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) - Son 13 Walk Ave, Owings Mills, MD 21117 Anthony W. Cascio Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet Cem 6/14/05 Garrison Forest MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Reisterstown, MD 21136 Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ATHEROSCLEROTIC CARDIOVASCUARDISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequents of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBRO VASCULAR INFARCIS DEMENTIA, 3 ☐ Probably 4 ☐ Unknown Completed PERINHERAL VASONAR OUTENE ATRIAL FIRRILLATION, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 Tes 2 No 2 □ No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3[] DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Adtural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funerel D 1 Destriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year)
TUNE III 2005 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mouthwest Hugpital Center (Kama swany 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrer	State o	f Marylan		artmen <i>rtificat</i>			and M	lental H	ygien Reg. N	0	From I grow you go
	· ·		1. Decedent's Name (First, Middle	e, Last)							2. Date of D	eath	C U U	3. Time-of Death
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	Director		215–16–2972 Usual Residence of Decedent		04						9/4/1	920	Ma	aryland
	arylanc show		10a. State 10b. County		10c. City	y, Town or L	ocation			-				10d. Inside City Limits
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	Physician	y 1	shock, or heart failure. List Immediate Cause (Final	only one cause on	line.	CL	000	0	. /	1	0	7.	LE	Interval Between Onset and Death
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FX	Fo the within 2 Fo the comple	Me	29b. Signature and the of certifier	1	1.1		29c.	License	number			29d. Da	ate signed (Mor	ith, Day, Year)
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	UX1		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)		4	()		J.V.	1	HU2005- BIR21014
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State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 🖔 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Cox Helen June 8, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Eldercare-Heritage Dundalk If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M & F 88 222-03-9390 Director July24,1916 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Wilmington De. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19804 USA 31 E. Champlain Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Heath and Mental Hygiene.
Int. If Item 27 is marked other than "natural, or Iter
Inty or other traumatic event, the Medical Examinator or other traumatic event, the Medical Examinator. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Electric Rubber Elementary/Secondary (0-12) College (1-4or 5+) Operator Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sophie Jastrzymski <u> Vincent Koterwas</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Village Court Bel Air, Maryland 21014 Edward Koterwas (brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/14/05 permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Lawn Mem Pk. New Castle, De. Grace 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, 1201 Dundalk Ave. Baltimore, Md 21222 23a. Part1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): WEAR ALLIDENT Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit P.O. Box 68760, Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No I Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending Injury after death.

Director: Aid in by the fu 2 No 1 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 10, 2005 D 27188 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Savinder K. Julka, M.D. 2 Market Place Dundalk, Maryland 21222 32. gistrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 3 2005 Registrar

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Mar & Bar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f ehow any injury or other treumatic event, Ite Madical Examiner must be pullified at once.		19a. Informant's Name/Relationshi Jane Daniels				Street, N					
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2/5 DIVI	or At after d Direct in by	Certification;	4 Homicide determin		y · At home, farm, s (Specify)	street, factory, office	2	28f. Location (S City or Tow		imber or Hura	ii Houte Numi	ber,
Janiels, William Division of Vital	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 🔀 Certifying	Physician: To the best of	my knowledge, de	ath occurred at the ti	me, date and place, a	and due to the o	ause(s) and	i manner as s	tated.	
De la company de	ne Ho n 24 h se Fun	Medical	(Check only 2 Medical Ex	caminer: On the basis of e	examination and/or	investigation, in my	opinion, death occurre	ed at the time, o	date and place	ce, and due to	the cause(s))
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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			Registrar 1. Decedent's Name (First, Middle, Last)						Date of Death	2005	3. Time of Death
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9	Examin		4a. Facility Name (If not institution, give street and num	ber)		4b. City, Town, o	r Location of	Death		4c. County of Death	1
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	or 28)ire	10e. Street and Number			10f. Zip Code			10	g. Citizen of What Co	untry?
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	sr deg	Funeral	Armed For		S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, White	
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215	hin 7;	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+)	(Give life. i	kind of work done DO NOT use retired	during most (d)	of working			
21	er the	Completed	10	,	Secre	tary				Federal G	overnment
DAVIS Maryland 21215-0036	be filed within 72 hours after death with the Marylan tati Hygiene. Indicate then "neturel", or Items 23e or 28e-1 ehow event, the Medical Expresser must be rediffied at	Be	17. Father's Name (First, Middle, Last)					·		laiden Surname)	
AVI	2 should be and Mental Is marked o	P	Strother M. Taliaferro		10h Maille	- Add (Chron			le Bea	City or Town, State, Z	- O - d -)
DA	d 2 sh th and 7 Is n treun		19a. Informant's Name/Relationship (Type, Print) Leahbelle Chilcoate (Da:	nohter)	1.	ayview W					(p C00 0)
H é	1 and Health tem 27 other to		20a. Method of Disposition			sition (Name of natory or other place		Date	-	Oc. Location - City or	Town, State
LEAH timore	Pages nent of int: If it		1XXBurial 2 ☐ Cremation 3 ☐ Removal from 5 1 ☐ Donation 5 ☐ Other (Specify)	cate		natory or other plac Nat. Ce:		nk.	A	rlington,	VA
LEAH Baltimore.	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumetic. ONGB.		21. Signature of Funeral Service Licenses	,		. Name and Addre	ss of Facility	,	-		
ñ	permi Depar Impor any ir		18-1-			Hardesty 12 Ridge	ly Ave	enue,	Annapo	lis, MD 21	401
	*		23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on each	used the death	Do not ent	er the mode of dyir	ng, such as c	ardiac or res	spiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nselen	te o	Cardiov	10> Cul	or L)iscas	S-e	Onset and Death
T	/Medical Examiner		resulting in death) Due to (or as a consequ	uence of):			-			
8	LAdillillei	_	Sequentially list conditions, b.	ur as a consecto							
_	led sit	nine	cause. Enter Underlying Cause (Disease or injury	N. Ga. G. COL SOCIO	ranka uty:						
_	lificate be executed g physician and as the burial-transit	Examiner	that initiated events c.	or as a consequ	uence of):						
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	tificati g phy as the	ledicai									
Вох	eath cert attendin for use	an/M	23b. Was decedent pregnant	come of pregnar		Ectopic pregnancy	v			23d. Date of deli	
	death	Physician/M	1 Yes 2 No 4 Pregn	ant at time of de		Other (specify)	,			Month	Day Year
0.9	that the de led by the a detached t	Phy	9 Unknown		-141 i- 4b	-4-4-3	on in Book		22a Did tab		the source of death?
	The law requires that the death centrate has been signed by the attendin bage 2 should be detached for use	þ	Part II. Other significant conditions contributing to de	ath but not resu	itting in the u	nderlying cause giv	ren in Part I.			acco use contribute to s 2 □ No 3 □ Pro	
0.00	w require been si should b	eted							<u> </u>		. 4
3ec	ne law has t	Completed							24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
0	icien: The certificate ha	e Co	25. Was case referred to medical				an Place			No 1 ☐ Yes	2□ No
S	Physicien: this certifica ral director,	To Be	examiner?	npatient 2 🗆 E	ER/Outpatier	it 3□ DOA Oth	. ^			nce 6 Other (Spec	ifv)
o	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of	f Injury h, Day Year)	28b. Time of Injury	Trial trial	ry at			w injury occurred	<i>ny)</i>
jo	Attending ir death. ector: After by the fune	atio	2 Accident investigation	1, Day 7 Sai)	Пушту		Yes 2□N	ło			
Division of Vital Becords.	ol or Attendi after death. I Director: Al d in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined buildin	of Injury - At ho	me, farm, str	eet, factory, office			Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Q	itelo Irs aft rel Di	O									
	e Hospitel 24 hours a e Funerel l letely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the base and many and many	isis of examinat	wledge, deatl tion and/or in	n occurred at the tir vestigation, in my o	me, date and pinion, death	l place, and h occurred a	due to the car t the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Mec	one) and mann 29b. Signature and title of certifier	or stated.		29c. Licens	se number		29	d. Date signed (Month	, Day, Year)
	+ 3 F 8		1X A Tourhul			172	876	59		6/7/0	5
	$^{\prime}$		30. Name and address of person who completed caus	of death (Item	23a) (Type,	Print) 126	2 Ce	nces for	(Hos	hur	
(1 1		Nicholos N. Borodus	ia cus	0	Fewer	ct &	Tolan	of P	199	44
- 1	Sta Registr		31. Date filed (Month, Day, Year) 2005	egistrar's Signat	ture	منا					

			1 - For State Registrar	State of Ma			of Health ar	nd Mental Hyo	giene Reg. No. 005	19569
	Physici		1. Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin		Robert E. Dorning 4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of	June Death	7, 2005 4c. County of De	11:30 PM
			6114 Tamar Drive			Columb			Howard	
	Funeral Director		5. Social Security Number 6. Se 211-12-0480 15	x 7. Age	(In yrs. last birthday,	If Under 1 \ Months E	Year If Under 24 Days Hours	Min. 8. Date of Birtl (Month, Pay MAR • 17		nthplace (State or Foreign Country) nnsylvania
	yland now		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Mar Ba-f sl	Director	MD Howard		Columbia					1 ☐ Yes 2X No
	E or 2	Dire	10e. Street and Number 6114 Tamar Drive			10f. Zip Co	045		10g. Citizen of What (Country?
	ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)	USA 14. Race - An	rencan Indian,
036	72 hours after death with the Maryland natural; or Items 23c or 28a-f show Jical Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 🗆 Divorced	Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates:	NAVY	1 ☐ Yes 2√x		Puerto Rican, etc.)		_{ite, etc.} vhite
215-0036	iithin 72 hours ne. han "natural', a Medical Exe	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use i	done during most d retired)		16b. Kind of Busines	·
7	filed within Hygiene. other than "		12 17. Father's Name (First, Middle, Last)		Vet	erinar	ian Assis	stant s Name <i>(First, Middle,</i>		ry Medicine
an	be be ave	o Be	Joseph Vincent Do	orning				lian Madara		
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (T Eileen Doyle - da					or Rural Route Numbe		Zip Code)
	1 and 1 Health em 27		20a. Method of Disposition		20b. Place of Disp	osition (Name	of	Columbia, N	1D 21045 20c. Location - City of	r Town, State
altimore,	Pages nent of int: If it		1 ☐ Burial 2 M Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	cemetery, cre Chesapeak	matory or othe	r place)	6/09/2005	Beltsvill	
<u>a</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lidens		2	2. Name and A	Address of Facility	omo Tna		
n	90,5 29		NISK. H	adem	5	555 Twi	n Knolls	ome, Inc. Road, Colu	mbia, MD	21045
	Physician /Medical		23a. Part1. Enter the sease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. mult		derosi	2	ardiac or respiratory an	est,	Approximate Interval Between Onset and Death
1	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):	Olise	use			15 years
3/60,	certificate be executed ding physician and ise as the burial-transit	dical Examiner	Cause (Disease or injury that inlitated events resulting in death) Last	cDue to (or as a	consequence of):					
ō	entifica fing ph		IF FEMALE:	20- 14	4					
O. Box	death e atter	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal death 3	⊒Ectopic pregr ⊒ Other (speci			23d. Date of de Month	elivery Day Year
ds, F.	se d	by P	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	underlying caus	se given in Part I.		bacco use contribute es 2 □ No 3 □ F	to the cause of death?
ecord	aw Is b	ompleted						24a. Was a		utopsy findings available
r	The ate h	Com						autop: perfor 1 Yes		completion of cause of s
Vital	Physiclan: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			The second secon	of Death (Check only or		
on or	ding After fune	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ☐ ER/Outpatie 28b. Time of Year) Injury		Injury at Work?		ence 6 \(\text{Other (Special Course)}\)	ecify)
DIVISION	al or Attending P s after death. Il Diractor: After t od in by the funera	ertifications	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	reet, factory, of			treet and Number or F n, State)	Rural Route Number,
	To the Hospitel or Attentwithin 24 hours after dealt To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy one) 1 Medical Exam	sician: To the best of iner: On the basis of and manner stat	examination and/or in	th occurred at the estigation, in	he time, date and my opinion, death	place, and due to the c occurred at the time, c	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the Within To the comp	ž	29b. Signature and title of certifier	10. 100			icense number	4	29d. Date signed (Mon	**
	1		Dary 11h	WS MIL)		5 665	1	June c	2005
	37		30. Name and address of p son who c	ompleted cause of de	ath (Item 23a) (Type,	Cellint.	bus MI	٥		
8	Sta	1.00	31. Date filed (Month, Day, Year)	32. Reostrai	's Signature	1.0.				
	Registr	ar	JUN I 3	ZUUD Mer	10 . 15	CARRELL				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of Ivialyla		rtificate of			Reg. No.	05	19570
	Physic /Medi		1. Decedent's Name (First, Middle, Last	GRT				2. Dete of De Month	Day	2005	3. Time of Death 1230 AM
1	Examir		4a Fecility Name (If not institution, give CROM WELL CE	street end number)			Bautim	or Location of Death	Ba	UTINO	
	Funeral Director		5. Social Security Number 217–26–0202 Usuel Residence of Decedent	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Yea Months Days			th y, Year) 1931		place (State or Foreign http) yland
	anylend show		10a. State 10b. County	10c. C	City, Town or Lo	cation				1	0d. fnside City Limits
	death with the Marylend rms 23a or 28a-f show Ir must be notitied at	Director	Maryland Baltimor	e Mi	ddle Ri						1 ☐ Yes 2 X No
	23a or 2	F	10e. Street and Number			10f. Zip Code 21 220			10g. Citizen o		itry?
	death	Funeral	24 Elm Drive	12. Was Decedent Ever in Armed Forces?	U,S. 13.		Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	U. S. 1	A • lace - Americ lack, White,	
020	72 hours efter natural', or ite ilosi Examine	þ	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1X Yes 2 No 19	VC7	I□Yes 212∏ No		,	Spec	cify:	nite
15-0	72 hours "natural", adicel Ex	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	lent's Usual Occu kind of work done	during most of w	orking	16b. Kind of		
21215-0020		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Offic	DO NOT use retir	9d)		United Milita		:S
	al Hyg Lother vent,	BeC	17. Father's Neme (First, Middle, Last)		OILIC	CT	18. Mother's N	ame (First, Middle,			
Maryland	should be filed withir nd Mental Hygiene. merked other than imetic event, the Ma	2	Bernard E. Eckert,		401 14 11			eth Charl			
	permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other treumetic event, the Monee.		Diane Marie Robert	7539 5		Newhaver		Rural Route Number			
ore,	es 1 a of Hes of Hem		20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b.	Place of Dispo- cemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location		
Baltimore,	t. Peg rtment rtant: I		4 ☐ Donation 5 ☐ Other (Specify)	Ba		rematory		6/13 2005	Baltim	ore, M	aryland
Ba	permit. Depertrimports any Inje		21. Signature of Funeral Service License	5 11 2 5	Bı	Name and Addr	ki Funer	al Home I	PA		3 21221
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the declared cause on each line.	ath. Do not ente	er the mode of dy	Eascern ing, such as cardi	AVENUE ac or respiratory as	rest,	Maryı	and 21221 Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	END S							Onset and Death
	Examiner	_	disease or condition resulting in death)	·	(or as a conseq						
_	uted 3 ansit	mlne)	for any and the same					<u> </u>	
, ,	e exectian enc	edical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(ur as a conseq	derics of .					
68760,	tificete be executed ig physician end es the bunel-trensit	Medica	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
Вох	ath cert ttendin or use			I						-	
P.O.	es thet the death ce igned by the attendii be deteched for use	Physician/	Part II. Other algnificant conditions con	•	_						the cause of death?
	gned b	by P	CONGESTIV	E HEAR	1 +7	97 LUK	E	- 10	Yes 2 INC	3 I Prot	pably 4 ⊡∕0nknown
of Vital Records,	aw requires been so should	Completed							an autopsy rmed?	ava	ore autopsy findings ailable prior to mpletion of cause death?
al R	: The I							101	′es 2 No	10]Yes 2⊡-No
Vit	Physician: The ribis certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 [☐ ER/Outpatien	t 3ELDOA O		eath (Check only o Home 5 ☐ Resid		ther (Specifi	v1
n of	ng Phy fler this	ino	27. Manner of Death 1 ☑Naturel 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of fnjury	28c. Inju		28d. Describe h			,
Division	Attending or death.	cation	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm stre		Yes 2 No	28f Location /5	Street and Nur	nher or Rura	l Route Number.
Ρį	tal or A	Certification:	4 ☐ Homicide determined	building, etc. (Spec		out, ractory, critica		City or Tow		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Tributo Wallibor,
	To the Hospital or Attending Physician: The is within 24 hours efter death. To the Funeral Director: After this certificete he completely filled in by the funeral director. page	edicai	29a. Certifier (Check only one)	icfan: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation end/or inv	occurred et the trestigation, in my	ime, date and plac opinion, death occ	curred at the time,	cause(s) and r date and place	manner as st e, and due to	eted. the cause(s)
	To the To the compl	Me.	29b. Signature end title of certifier	/			se number		29d. Date sign		
	181		· Cofin the	il, mp			01618	79.	lune	11	2005
	57		30. Name and address of person who co		em 23a) (Type, I Loc4)	Print	BLUD,	BALTING	RE, N	10 21.	139.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign		٧					

State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No: 0 5												A Commence of the Commence of	19571			
				Registrar Certificate Of Death Decedent's Name (First, Middle, Last)							2. Date of		40:	J 1,5	3. Time of Death	
	Physici		Allen								June		2005	Year	6:00 a M	
	/Medic Examin		4a. Facility Name (If not institution	on, give street and numb			4b. City,		Location (of Death		-	4c. Count	of Death	0.00 a	
1	LAGITIII	CI	4742 Flanders Lane, J					Harwood					Anne Arundel			
	be filed within 72 hours after death with the Maryland and Hygiene. ad other than "neturel", or Items 23a or 28e-f show and other than "neturel", or Items 23a or 28e-f show and other than "neturel", and the mailtent at		5. Social Security Number	Age (In yrs. I	ast birthday)	If Under 1 Year If Under 24 Hrs.			8. Date of	Birth			place (State or Foreign			
			231-54-2622 ^{1፟™ 2□ F} 61				Yrs. Months Days Hours Min.					Day, Yea L 7, 19	944 Virginia			
			Usual Residence of Decedent										10d Inside City Limite			
		<u>_</u>										1 ☐ Yes 2 ☐ No				
		ect	MD Anne Arundel Harwood 10e. Street and Number 10f. Zip Code									140	7			
		D.	4742 Flanders Lane, J							,		10g. 0		What Cour	ntry?	
		eral									acify Vac or	No-		SA SA Amorio	can Indian,	
Maryland 21215-0036		Funeral Director	1 ☐ Never Married 2 ☐ Ma	35? ՃNo	If Yes, specify Cuban, Mexican, F			n, Puerto	Rican, etc.)	110	Black, White, etc.					
		þ	3 ☐ Widowed 4 Divorce		1 ☐ Yes 2 No Specify:								Specif	Specify: White		
		sted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo							t of work	rina	16b.	b. Kind of Business/Industry			
		To Be Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired) (Give kind of work done during most of wo life. DO NOT use retired)						i oi work	arig						
21	filed w Hygier Sther th		6			Carpe	nter							struc	tion	
and	permit. Pages 1 and 2 should be fill Department of Health and Mental H Importent: If Item 27 1e marked oth any injury or other traumatic even once.		17. Father's Name (First, Middle	, Last)								e (First, Middle, Maiden Surname)				
ž			Ray Fannon 19a. Informant's Name/Relation	schip (Tuga, Print)		10h Mailie	an Addraga	/Ctrant a			ibson		T	04-4- 71	0-4-1	
Ma			Allen Fannon,								al Route Nur Harwo				(Code)	
			20a. Method of Disposition	UL. (DOII)	20b. P	lace of Dispo	sition (Nam	e of	Ţ		Date	-		City or To	own, State	
Baltimore,			1X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (ne [emetery, crer emont				6/8/	2005	3		-	e, MD	
ati			21. Signature of Funeral Service		Hak	22	. Name and	Addres	s of Facilit	ty				IIVILI	.е, по	
ä			178- 4. C	K-		- 1	Harde 12 Ri	sty dge1	rune:	ral enue	Home,	P.A.	s. M	0 214	.01	
	Physician /Medical Examiner	X.	12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between													
			Immediate Cause (Final disease or condition	Red	+61	Ca	ncei								Onset and Death	
			resulting in death)	Due to (or	as a consequ		/ 1 CC /								egears	
	Examiner		Sequentially list conditions,	b		1.0										
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, reading to infimediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ianea ot).										
		хап	that initiated events resulting in death) Last	c. Due to (or	Due to (or as a consequence of):											
8760,		cal E														
687	ate the	edic		d												
Вох	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours atter death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome of pregnancy								23d. Date of delivery			
m.		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						_		Month Day Year			
P.0		hys	9 Unknown													
Ś		by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Di	d tobacco	cco use contribute to the cause of death?			
ord		ted									1 [Yes	s 2 No 3 Probably 4 Unknown			
Vital Record		Completed									24a. Wi	as an topsy	24b.	Nere autoportion	psy findings available appletion of cause of	
H												performed? death?				
Vita		Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)													
o		T.	27. Manner of Death 1 Manual 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined.								Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,					
		ton														
Division		ertification														
Ö		Certi	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)													
			29a. Certifier (Chock only (Ch													
		ledical	and manner stated.													
		Σ	29b. Signature and title of certifier 29c. License number D5 Z 8 3 0							29d. Date signed (Month, Day, Year)						
,	\propto										June 4,2005					
2	\		30. Name and address of person Jeanine Wei	who completed cause of	of death (Item	23a) (Type,	Print)	Sinor	12.	1.0	1.0	2017)	(1,-1		
0			31 Date filed (Month Day Year	22. Regi	strar's Signat	ure /CC/2/2	0(-	,00/	IIIIV	icepu	1/3 , 1	1117	V	701		
	Sta	te 🗀	31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature													

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June **Physician** Charlotte M. Fischer 2005 7:07 ΡМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 1905 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🕅 F 99 Yrs Director 216-44-3905 Washington, D.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Madical Examiner must be notified at Director Maryland 1 ₹ Yes 2 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 333 Russell Avenue #319 20877 United States or itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW II 1 ☐ Yes 2X No Specify. White þ Specify 3 Widowed 4 Divorced natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 ia marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Fischer Minerva Harrington ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Walker/Nephew 42977 Cool Spring Lane, Ashburn, Virginia 20147 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö June 11, injury Prospect Hill Cemetery 2005 A □ Donation 5 □ Other (Specify) Washington, D.C. Robert A. Pumphrey Funeral Home/Rockville, 21. Signature of Funeral Service Licensee nny i 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final meumonia Priysician Lday disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medlcal attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? þ 1 🗌 Yes 2 PNo 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Division of Vital 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death Check onl one) examiner? Other: 4 v ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in 24 hour.
Itha Funaral Direc. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 004115 June 7, 2005 und of person who completed cause of death (Item 23a) (Type, Print), SCHBART MI 32 Registrar's Signature 31. Date filed (Month,

Registrar

386	81		1 - For State Registrar	State of M	laryland /		artment				lental H			05	19	1573
	_		Decedent's Name (First, Middle,	Last)			rimoate	, OI L	Julin		2. Date of D	Reg. I	No.		3. Time o	of Death
п	Physici		James	Wa	llace			Gr	een		JUNE	6	oay 200!	5 ^{Year}	2040	
	/Medic Examin		4a. Facility Name (If not institution,				4b. City,			of Death			4c. County			
			1248 N. AUGUSTA	AVENUE			BALTI	EMORI	E CTT	Ϋ́						
	Funeral Director		5. Social Security Number 214-14-5739	3. Sex 7. A XIXM 2□ F	ge (In yrs. last b 84	oirthday) Yrs.	If Under Months		If Under Hours		8. Date of E (Month, I	Birth Day, Yea	20	Cou	olace (State ntry) MD	or Foreign
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	289-	Director	MD NA 10e. Street and Number		Balt	1 mo	re 10f. Zip	Code				10g (Citizen of W	Vhat Cou		
	3e or		1248 North Aug	nusta Ave					229					S.A	•	
	deatl	Funerai	11. Marital Status	12. Was Deceden		13.	Was Deced			igin? (Sp	ecify Yes or N Rican, etc.)	10-	14. Race	e - Americ	can Indian,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other treumatic event, it a Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3X Widowed 4 ☐ Divorced		No		n Yes, spec 1 ☐ Yes 2		Specify:		Hican, etc.)		Specify	k, White,	etc. lack	
Ö-	72 ho	Completed	15. Decedent's (Specify only highest	Education	16	a. Dece	dent's Usua	l Occupa	tion	e at comple	in a	16b.	Kind of Bu	siness/In	dustry	
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<u>a</u>	d 2 sl th an th an treur		Ellen Presco-		7						al Route Num Ave,					1220
Đ	1 an Heal tem 2		20a. Method of Disposition		20b. Place						Date	_	Location -			,1229
ē	ages ant of nt: if i		Magazian 2 ☐ Cremation 3	Removal from State	'				,	c /1 E	. /05					M -3
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tree		21. Signature of Funeral Service Li		Garr	M.	n For arch	Address	of Facili We:	št	5/05				lls,	
	40260		23a. Part1. Enter the disease, or co	tt. Inm	provide Do						Balt		re,	Md	2121	
	*		shock, d heart failure. List of	nly one cause on each	line.							arrest,			Approxima Interval Be Onset and	tween
	Physician /Medical		disease or condition resulting in death)	a. 505	vointes	stei	ral	HeV	Uars	ma	ge_					
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P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal deat at time of death		Ectopic pre Other (spe						23d. Date Mon		-	Year
	res that igned to be deta	by P	Part II. Other significant condition	s contributing to death	but not resulting	in the ur	nderlying ca	use giver	n in Part I		23e. Did	tobacco	use contri	bute to th	e cause of	death?
ğ	w require been sig should b	edt									1□	Yes	2 🗌 No	3 🗌 Prob	ably 4 📝	Unknown
Records,	he law re e has bea ge 2 sho	Completed									per per	s an opsy formed?	pr de	rior to cor eath?	psy findings apletion of c	available cause of
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\leq	ysici is cer direc	To B	examiner? X Yes 2 No	Hospital:	ent 2 ER/O	utpatien	nt 3□ DOA	Other			me 5□Res		6 X Othe	r (Specifi		Æ
Division of	ding Ph h. After th funeral	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Date)	ury 28b.	Time of Injury	28 M	ic. Injury	at		28d. Describe				,	
S	f or Attendi after death. Director: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Ir	jury - At home, f	arm, str					28f. Location	(Street a	and Numbe	or or Rura	l Route Num	nber.
á	ospital or A hours after uneral Dire		4 nomidae	building, e	tc. (Specify)					1	City or To					
	124 H	Medicai	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the besi caminer: On the basis of and manner s	of examination a	je, death nd/or inv	occurred a vestigation, i	t the time in my opi	e, date an nion, dea	d place, a	and due to the ed at the time	cause(, date a	s) and man	ner as st nd due to	ated. the cause(s	3)
	To the within To the comple	Σ	29b. Signature and title of certifier	talla 1	us d			OCM	Œ			JUI	vate signed $\times 7$,	. 200)5	
6			30. Name and address of person w	no completed cause of	death (Item 23a)	(Туре,	Print) 111 F	enn	Stre	et	Baltim	ore,	Mary	vland	2120	1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rays Signature	Js.	Ace	the s								
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			1- State of Ma Registrar Amend Item 28b per me	ryland / Depa G845 / Depa Cer	urtment of Health and I TOS tas tificate of Death	Mental Hygio	ene2 () () 5 g. No.	19574
	Physici	0.0	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dav Year	3. Time of Death
	Physici /Medic		Michael	Leon	Grimes	June 9,	2005	6:55 a.™
	Examin	er	4a. Facility Name (If not institution, give street and number) 500 E. 27th Street, vacant	1ot	4b. City, Town, or Location of Death Baltimore City	1	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		217-90-8336 XXM 2DF	27 Yrs.	Months Days Hours Min.	(Month, Day,) 07 04	Year) Cou	MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			I Od. Inside City Limits
	Marylan -f show fied at	ţ	MD NA	Baltimo	re			XXYes 2 □ No
	n the	irec	10e. Street and Number	BUICING	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	ath wi	rai	3613 Campfield Road		21207		U.S.A.	
36	ges 1 and 2 should be illed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If the alten 27 is marked other than "naturel; or iteme 23a or 28a-f show of other treumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status XXVever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E: Armed Forces? 1 ☐ Yes 2 ☐ XNC If Yes, Give Year or Dates:)	Vas Decedent of Hispanic Origin? (S _I i Yes, specify Cuban, Mexican, Puert I ☐ Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White, Specify:	
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Maryland	12 should be filled within h and Mental Hygiene. 7 is marked other than " reumatic event, the Mer	Be c	17. Father's Name (First, Middle, Last) Lenwood L. Grimes		Tanya H		alden Surname)	
ary.	shoul nd Me mark	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Ru		City or Town, State, Zip	Code)
Ž,	and 2 palth a palth a partre		Tanya West-Mother		Kerrigan Ct,		stown, Mo	21133
Baltimore,	Pages 1 nent of He ant: if iten ary or oth		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date 20	Oc. Location - City or To	own, State
ţi	t. Pag nment rtent: njury		4 ☐ Ponation 5 ☐ Other (Specify)		norial Park 6/1 Name and Address of Facility	.4/05 R	andallsto	own, Md
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Ш			23a. Part . Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	the death. Do not ento a.	er the mode of dying, such as cardiac	or respiratory arres	et,	Approximate Interval Between Onset and Death
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Ä	The ate h	Com				performe 1 🔀 es 2	ed? death?	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Oth	th (Check only one)		
of	S 50	. To	27. Manner of Death 28a. Date of Injury	t 2 ER/Outpatien		ome 5 Residen 28d Describe how	ce 6 Other (Special	At scene
n	Attending Phy ir death. ector: After thi by the funeral (ation	1 Natural 5 Pending Found Month, Day 2 Accident investigation	Year) Injury	28c. Injury at Work? 1 □ Yes 2 ☑ No	SUBTECT		TED
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	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or inv	vestigation, in my opinion, death occu	rred at the time, dat	e and place, and due to	the cause(s)
	To T	Σ	29b. Signature and title of certifier	. ~ (29c. License number		d. Date signed (Month,	
	d		J.M. Jt	- MiDi fe	OCME		June 9, 200	J
5			30. Name and address of person who completed cause of de)	111 Penn Street	Baltimor	ce, Marylar	d 21201
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 3 2065	House B	! Sperled			

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	ō		Registrar 1. Decedent's Name (First, Middle, Last)	^		Reg. 2. Date of Death		3. Time of Death
	Physic /Medi		Abadosil 3	GARR	ett	Month	6. 100 S	1242 W
	Examir		4a. Facility Name (If not institution, give street and number)er)	4b. City, Town, or Location of Deat	h	4c. County of Death	
			Catonsville Commons 5. Social Security Number 6. Sex 7.	And the same to as high days	Catonsville		Baltim	
П	Funeral Director	Н	215-07-7245 1□ M 2 🗗 F	. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birth	olace (State or Foreign
	ס		Usual Residence of Decedent			Par /, I	JIJ PAL	yland
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "nature!", or items 23e or 28e-f show event, the Medical Examinar must be multified at	tor	Maryland Baltimore	10c. City, Town or Lo	ocation SVille			0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	h the	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?
	th wit	alD	6128 Moorefield Road		21228		United St	tates
	or dea	uner	11. Marital Status 12. Was Deced Armed Forc	es?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Americ Black, White,	can Indian,
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	12 s h ar 7 is treu		Joan E. Moritz / Daughter		Hawkins Street, S			
re,			20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)		Location - City or To	
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Baltimore,	permit. Pag Department Importent: i any injury o		7. Signatu - of Funeral Service Licensee		. Name and Address of Facility Hu			
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Sio	Attending r death. sctor: After by the funer	catl	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	or At after d Direct in by	Certification:	determined 200. Place of	Injury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural ate)	Route Number,
_	Hospitel or 24 hours afte Funerel Din tely filled in I		29a. Certifier 1 Certifying Physician: To the be	est of my knowledge death	occurred at the time, date and place	and due to the cause	(s) and manner on -t-	atad
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the beside and manner 1 Medical Examiner: On the basis and manner	of examination and/or inv stated.	estigation, in my opinion, death occur	red at the time, date a	and place, and due to	the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier		29c. License number		Date signed (Month, L	
			· Creetra Raya us		D27541	Tu	ne 7, 20	05
	2		30. Name and address of person who completed cause of SEETHA RAJH MD 43	f death (Item 23a) (Type, F 367 Hollins j	serm Rd, salt	inone, Mi	0 - 2122.	7
	Sta	te	31. Date filed (Month, Pay, Year) 32. Re JUN 1 3 2005	strar's Signature	•			
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NOLA	Division of

			1 - For Stata Registrar		Maryland / [-	rtment			and M	-	giene	2005	0 1957
	Physici /Medic		1. Decedent's Name <i>(First, Middle, L.</i> Nola	ast)	1	Hugh	nes				2. Date of Dea	9 Day	2005 ^{ar}	3. Time of Death 5:25a M
	Examir		4a. Facility Name (If not institution, grant Stella Maris F 5. Social Security Number 6.	Mospice	ber) 7. Age (In yrs. last bin			noni	Location out		9 Date of Bird		Baltimo	re
	Funeral Director			1□ M 2∏ F		Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day 4-19	y, Year) -41	9. Birth	place (State or Foreign intry) Md.
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow Jissi Evaritrar must be notified at	Funeral Director	Md. 10b. County Md. NA 10e. Street and Number		10c. City, Town		more		•			10g. Citiz	en of What Cou	10d. Inside City Limits 1 X Yes 2 ☐ No intry?
900	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f ahow edical Evertiner must Le molified al	d by Funeral	534 N. Curley St 11. Marital Status 1√√ Never Married 2 Married 3 Widowed 4 Divorced		2 □X \0	1	1			gin? (Spe	ocify Yes or No- Rican, etc.)		USA 4. Race - Ameri Black, White	
21215-0036	d within jiene.	Completed by	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 12th grade	rade completed) College (1-		(Give k. life. Di	ent's Usual ind of work O NOT use Drive	k done d e retired) ⊇ Ľ	uring most			City	d of Business/Ir Wide B	
Maryland	a la	To Be	17. Father's Name (First, Middle, Las Vernon	t)	Hawkin	ns				r's Name rnie	(First, Middle,	Maiden S	Gumame) Willi	ams
lary	2 should and Men Is marka	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing	Address	(Street a				r, City or	Town, State, Zij	
Baltimore, N	Pages 1 and 2 should nent of Health and Mer int: If item 27 Is marks iry or other traumatic		Willie Garcia 20a. Method of Disposition ***XBurial 2	☐Removal from S	late	Disposi y, crema	ition (Nam atory or oti	e of her place)	D	, Balti ate 4-05	20c. Loc	ation - City or T	
Balt	permit. Pages. Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 2.											
	Pnysician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEPATOCELLULAR CANCER Due to (or as a consequence of):												
8760,	ate be executed hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequence o									
.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live bir	ome of pregnancy th 2 Fetal death nt at time of death wn		Ectopic pre Other (spe					23	d. Date of delive	ery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to dea	ath but not resulting in	the und	derlying ca	use give	n in Part I.					he cause of death?
Vital Records,	The la ate has page 2	Completed									24a. Was a autop: perform 1 Yes	med?	prior to co death?	psy findings available mpletion of cause of 2 No
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	patient 2 ☐ ER/Out	tnatient	3 DO	Othe			(Check only or		© Other (Specif	W HOSPICE
sion of	Attending Phys r death. actor: After this by the funeral di	atlon: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of (Month				c. Injury Work	at ? es 2 🗆 N	2	8d. Describe h			nosi ice
Division	n lite	Certification:	3 Suicide 6 Could not l	buildin	of Injury - At home, far g, etc. (Specify)					W	City or Town	n, State)		al Route Number,
	the Hospital of the Hospital of the Eunaral Eupletely filled in	edical	29a. Certifier (Check only one) Certifying P	hysician: To the t minar: On the bas and mann	pest of my knowledge, sis of examination and er stated.	, death o dor inve	occurred a estigation,	t the time in my opi	e, date and nion, deat	d place, a h occurre	nd due to the c d at the time, d	ause(s) a ate and p	nd manner as s lace, and due to	tated. the cause(s)
)	withir To th	Me	29b. Signature and title of certifier				29c.	License	number	12	5	9d. Date	signed (Month,	Day, Year)
-	7		30. Name and address of person who DR. TARIQ MAHMO		of death (Item 23a) (,)_ 7	'TMON	тим	MD 210	93		
•	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	istrar's Signature				. IIIVIII		210	,,,		
DH	MH 17 Rev 1/20	001		-	BULL IS.	19								

			1 - For State Registrar	State o	f Maryland / Dep <i>Ce</i>	artment of F		, ,	iene	n c	10000
	Division		1. Decedent's Name (First, Middle	, Last)				2. Date of Deat	h	U)	3. Time of Death
ı	Physici /Medi		Erma		Toyer	н	olt	June	Day 21	A.S	EYO'ON AM
	Examir		4a. Facility Name (If not institution			4b. City, Town, o			4c. County	of Death	00, 5.
			Union Memoria			Baltim					
Т	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth (Month, Day, 03 07	Year)	9. Birthi	place (State or Foreign
	Director		216-36-5265 Usual Residence of Decedent		66 Yrs.			03 07	39		MD
	land		10a. State 10b. County	-	10c. City, Town or L	ocation					I0d. Inside City Limits
	Mary f sh	tor	MD NA		Baltimo	re					1 X Yes 2 □ No
	1 tha	Director	10e. Street and Number	•	Darcinc	10f. Zip Code		10	g. Citizen of W	hat Cour	ntry?
	h with	0	2530 Boarman	Δνρ		2	1215			5 . A .	,
	deet	Funeral	11. Marital Status		dent Ever in U.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)			an Indian,
9	after or its	F	1 Never Married 2 Marr		2 No	in Yes, specify Cuba 1 ☐ Yes 2 X ☐ No		Puerto Rican, etc.)		k, White,	etc.
8	ural',	d by	3 X Widowed 4 □ Divorced	Year or Da	ates:	10 165 25 100	эреспу.		Specify.	Bl	ack
15-	within 72 hours atter deeth with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Examiner must be retified at	Completed	15. Decedent (Specify only highes	's Education t grade completed)	(Give	dent's Usual Occupa	durina most o	f working	6b. Kind of Bu	siness/In	dustry
12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1	-4or 5+)	DO NOT use retired	"				
р Б	be filed ital Hygi d othar evant, t		7th grade 17. Father's Name (First, Middle, 1	Last)		Nanny	18 Mother's	Name (First, Middle, M		vat	e
an	ld be ental ked c	To Be	Howard King	•						,	
ary	2 should be filed within 72 hours atter deeth with tha Marylan and Mental Hygiene. Is marked other than "natural", or itams 23a or 28e-f show eumetic evant, the Medical Eraniiner must be notified at	-	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ng Address (Street a		thy F. To			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 ia marked, any injury or other freumetic evone.		Kathy Holt-Ph	illips-							21215
Ore	of He of He ritem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place			0c. Location - 0		
Ĕ	Pag ment ant: i		1√2 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	ecify)	State	Memori	1	/16/05	rbutus	M	a
3alt	epart epart nport ny inj		21. Signature of Funeral Service I	icensee	22	arch F/I	s of Facility		coucus		4
	20529	11	/ Jala	Mari	4	300 Waba	ash A	ve, Baltin	more,	Md	21215
Ι.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	sused the death. Do not ent	er the mode of dying	g, such as ca	rdiac or respiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. C. D1	or as a consequence of):	ve Disea	sse				Onset and Death
	/Medical Examiner		resulting in death)			1					
Н		e	Sequentially list conditions, if any, leading to immediate	b. <u> </u>	or as a consequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	3.7.						
Ć,	exection and ital-tra	Еха	resulting in death) Last	C. Due to (or as a consequence of);						
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dlcal		d							
ၑ	artifica ing ph e as tl	Med	IF FEMALE:								
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	come of pregnancy rth 2 Detail death 3 December 2 Representation of the comments of the commen	Ectopic pregnancy			23d. Date		2
0	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unkno		Other (specify)			Mont	п	Day Year
₾.	res that the de signed by the a l be detached t	Ph	Part II. Other significant conditio	ns contributing to de	ath but not resulting in the u	nderlying cause give	n in Part I	23e Did toba	cco use contrib	uto to th	e cause of death?
Records,	quires n sign ald be	d by							./		ably 4 Unknown
Ö	s been si	Completed						24a. Was an	24h W	ere autor	sy findings available
	The lav	mo						autopsy performe	ed? pri	or to con ath?	npletion of cause of
Vital		0	25. Was case referred to medical				26. Place of	1 Yes 2 Death (Check only one)	No 1	Yes	2 No
>	Physic this ce al direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 1	patient 2 ER/Outpatien	t 3 DOA Othe		ng Home 5 Residence	ce 6 ∏Other	(Specify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o (Month	Injury 28b. Time of Injury	28c. Injury Work		28d. Describe how			,
Sio	ttandi death. ctor: A y the fu	cati	2 Accident investig	ation			es 2 □ No				
Division of	or Attand after death Diractor: /	Certification:	4 Homicide determine	ned 286. Place	of Injury - At home, farm, stre g, etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Stree City or Town,	et and Number State)	or Rural	Route Number,
_	pital ours a marai I		29a. Certifier 1 Certifying	Physician: To the	20 of of my knowledge, death						
	24 h	edical	(Check only 2 Medical E	xaminer: On the ba	pest of my knowledge, death sis of examination and/or inverses stated.	estigation, in my opi	e, date and pi inion, death d	ace, and due to the cause occurred at the time, date	se(s) and manr a and place, an	ner as sta d due to	ited. the cause(s)
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Month, D	Pay, Year)
	0		Kyoka in	Wis, UD		ATAY	3894	6	June 9	200	16
1	,		30. Name and address of person w		of death (Item 23a) (Type, I	Print)	1911	6 Baltinere	10/	, vec	9
4			hisha Davis	UD Unio	on Memoria	O HOSPU	af E	Baltimere.	MED		
	Stat Registra		31. Date filed (Month, Day, Year)		gistrar's Signature	4 Knowl	,	,			
		1.	J	JN 1 3 200	JUNEAR JO	Spence					

			For State Registrar	State	of Maryl	and / Depa	artment of rtificate of	Health Death	and M	lental Hy	gien Reg. N	comp of the	5	9	578
	Dhusisi		1. Decedent's Name (First, Middle, L	ast)						2. Date of De	eath		'ear		of Death
	Physici /Medio		Catherine Hymil							June		2005 Y		2:30	а м
	Examin	ier	4a. Facility Name (If not institution, gr Stella Maris Ho		imber)		4b. City, Town, Timoni		of Death		40	c. County <i>of</i> B		imore	
	Funeral			Sex	7. Age (In)	rs. last birthday)	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bi	rth	1 9	Birthpl	lace (State	or Foreign
	Director		215-05-4487 Usual Residence of Decedent	1 □ M 2 □ X =	94	Yrs.	World S Cays	riogis	Will to	May 28	, 19	11		land	
	yland Now		10a. State 10b. County		10c.	City, Town or Lo	ocation						10	0d. Inside	City Limits
	e Mar ta-fsh	ctor	Md. Harfo	rd			Jop	ра						1 🗆 Ye	s 2≹∑No
	with th	Dire	10e. Street and Number	D			10f. Zip Code	005				itizen of Wh	at Coun	try?	
	ns 23	eral	535 Joppa Farm 11. Marital Status	12. Was Dec	edent Ever i	n U.S. 13.	Was Decedent of If Yes, specify Cu	085 Hispanic Or	rigin? (Spe	ecify Yes or Ne		14. Race -	America	an Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other traumatic event, I're Medical Examinar must be notified at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 ∐Yes If Yes, G Year or t	2€ No ive		If Yes, specify Cu 1 ☐ Yes 2 🛣 No			Rican, etc.)		Black, Specify:	White, 6		
2	72 hor	eted	15. Decedent's E)	(Give	dent's Usual Occu	durina mos	st of worki	ina	16b. F	Kind of Busi	ness/Ind	lustry	
121	within so e.	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retir	ed)		9		.iotio	_		
2	Hygie bther ent, II	Be Co	8 years 17. Father's Name (First, Middle, Las	it)		LIV	eter	18. Moth	er's Name	(First, Middle		7iatio n Sumame)			
/lan	should be and Mental I smarked of umatic eve	To B	Charles Snack					Aı	nna D	iese1					
Maryland 21215-0036	alth and 27 is ma		19a. Informant's Name/Relationship Carolyn Snee/da				ng Address <i>(Str</i> ee Joppa Fa							Code)	
Baltimore,	es 1 a of Hei fitem rothe		20a. Method of Disposition 1 5 Burial 2 ☐ Cremation 3	Bemoval from		b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	асе)	С	Date	20c. L	ocation - Ci	ty or To	wn, State	
Ĕ	t. Pages tment of I tant: If it		* 4 ☐ Donation 5 ☐ Other (Spec	ify)	F		11 Mem.				_	ld1e R			
Ba	Departing Control of C		21. Signature of Funeral Service Lice	ensee P	lini	11-1	Schimune 610 W. M								
			23a. Part1. Enter the disease, or conshock, or heart failure. List ont	nplications that y one cause on	caused the deach line.	leath. Do not ent	er the mode of dy	ing, such as	cardiac c	or respiratory a	irrest,			Approxim Interval B Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		AST CAI										
	Examiner			Due to	(or as a con	sequence of):									
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss of Injury that indicated events	Due to	(or as a con	sequence of):									
	xecute and il-trans	Examiner	that initiated events resulting in death) Last	c	(or as a con	sequence of):							-		
8760,	licate be executed physician and s the burial-transit	dicai E		d											
89	ertifica ing phy e as th	0	IF FEMALE:												
.О. Вох	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown		birth 2 ☐ F nant at time :	etal death 3	Ectopic pregnand Other (specify)	су				23d. Date of Month		ry Day	Year
ت. ح.	s that t ned by e detac	y Ph	Part II. Other significant conditions	contributing to	death but not	resulting in the u	nderlying cause g	ven in Part I	I.	23e. Did 1	tobacco	use contribu	ute to the	e cause of	death?
Zg	w require been sig should b									1 🗆	Yes 2	!□No 3	☐ Proba	ably 4X	Unknown
Records,	ne law r has be ge 2 sh	Completed								24a. Was		24b. We prio dea	re autop	sy finding	s available cause of
		e Col	25. Was case referred to medical							1 Yes	2 X No		Yes :	2 🗆 No	
=	ysicia is cert	To Be	examiner?	Hospital:	Inpatient 2	2 ER/Outpatier	nt 3 DOA	hoc		n <i>(Check only o</i> me 5 ☐ Resi		6 XOther	(Specify	HOS	PICE
Division of	는 는 등	on; T	27. Manner of Death 1 X Natural 5 ☐ Pending		of Injury oth, Day Year					28d. Describe				HOD	LIOI
<u>Si0</u>	ttendi death. stor: A	icati	2 Accident investigation 3 Suicide 6 Could not	be 380 Blac	o of Injune - A	It home form etc	M 1	Yes 2		28f. Location (Stroot	nd Number	or Pumi	Courte Mu	mhar
2	al or A s after i Direction by	Certification;	4 Homicide determine	build	ting, etc. (Sp.	ecify)	eer, ractory, onice			City or To			or murar	Honte 140	TIDEI,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1X Certifying F	miner: On the	e best of my basis of exam	knowledge, deat nination and/or in	h occurred at the t vestigation, in my	ime, date ar opinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s date an	and mann d place, and	er as sta d due to	ated. the cause	(s)
	To th within To th comp	Me	29b. Signature and title of certifier)			29c. Licen	se number			29d. Da	ate signed (/	Month, D	Day, Year)	
	,			1-			10	737	52			Ce/1	0/0	5	
	6		30. Name and address of person who					WT	T15-	.m. 0					
	Sta	te.	DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)	32.1	DULAN egistrar's Si	VEY VALL	EY RD.	T.TWON.	LUM,	MD 210	93	· · · · · · · · · · · · · · · · · · ·	-		
	Registr		JUN 13	2005	Koline	ignature A									

2:30 а.ш.

JUNE 10, 2005

CATHERINE HYMILLER

			State of Maryland / Department of Hear Registrer Certificate of De	alth and Me	ental Hygi	ene	t on the man of
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg	g. No.	19579
п	Physici	an	Richard W Hunter Sr.		Month	Day Year	3. Time of Death
	/Media	cal			June	9 200	
4	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lot			4c. County of Deat	
				ville		Montgome	
п	Funeral			Under 24 Hrs. 8	B. Date of Birth (Month, Day, 1) [ay 27,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	Į.	lay 27,	1936 Uta	an
	land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary	ō	Maryland Montgomery Gaithersburg				1 X Yes 2 □ No
	the 28a	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Co	untar?
	with e or	۵	337 Chestertown Street 2087	Q		Inited Sta	•
	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28a-1 show ha Medical Examiner must be notified at	by Funeral				14. Race - Ame	
	ter deal	-F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 No 1959— 13. Was Decedent of Hispa	Mexican, Puerto R	can, etc.)	Black, White	
3	urs al	b		Specify:		Specify: W	hite
21215-0036	2 hou	Completed		n	16	6b. Kind of Business/	
55	nin 7. na na Manda	pie	(Specify only highest grade completed) (Give kind of work done during life, DO NOT use retired)	ng most of working		Consulting	
72	1 within 7 jiene. r then "n	E 0	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Senior Vice Pres		4	ntergratio	
ğ	filed Hyg Sthe Ent,	· o	17. Father's Name (First, Middle, Last) 18.	. Mother's Name (
an	D 50 00	To B		Muriel H			
7	d 2 should th and Mer ?7 is marke treumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and			City or Town State 7	in Code)
Maryland	d 2 street		Lauris B. Hunter / Wife 337 Chestertown				
á	is 1 and of Health item 27 other tr		20a Method of Disposition 20b. Place of Disposition (Name of	Da	ta 20	oc. Location - City or	
9			1 Burial 2 Cremation 3 Removal from State Arlington National	Augusi	22,		
뜵	nit. Parantinen oortent; injury		Cemetery	2005		arlington,	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service 1. Service 1. Name and Address of Robert A. Pumph:	rey Funera	1 Home/Ro	ockville, In	c.
	40260		101303 300 West Montgo	mery Aven	ie, Rockvi	ille, Maryla	nd 20850-2805
			23a. Part 1. Excer the disease, or complications that caused the death. Do not enter the mode of dying, st shock, or heart failure. List only one cause on each line.	uch as cardiac or	respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Sepsis				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				- ***
	Examiner		Sequentially list conditions b.				
-	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
/	cuted ord rans	Examiner	that initiated events				
o	an an arrial-t		resulting in death) Last Due to (or as a consequence of):				-
68760,	death certificate be executed e attending physician and of for use as the buriat-transit	ical	d				
	death certificat attending phy d for use as th	led					
Вох	h cer endir use	In/N	IF FEMALE: 23b. Was decedent pregnant 1			23d. Date of deliv	very
<u>.</u>		icis	1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
P.O.	t the by th ache	hys	9 □ Unknown				
	The law requires that the tee has been signed by th bage 2 should be detache	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	quire n sig uld b		Renal failure		1 🗆 Yes	2 🗆 No 3 🗆 Pro	bably 4 🗷 Unknown
Records,	w rec	Completed			24a. Was an	24h Worn aut	opsy findings available
Re	The lav	mc			autopsy	prior to co	ompletion of cause of
a	iicien: Th certificate rector, pag		25 Was seen referred to an direct		1 Yes 2 €		2□ No
Vital	iding Physicien: th. After this certifica	Be		. Place of Death (
of	Phys this ral di	2	1 Empatient 2 ER/Outpatient 3 DOA			e 6 Other (Special	fy)
Division	Attending r death. sctor; After by the fune	Certification:	1- Natural 5 Pending (Month, Day Year) Injury Work?		d. Describe how	injury occurred	
<u>s</u>	l or Attencatter death Director:	ca	2 Accident investigation 3 Suicide 6 Could not be				
<u>≥</u>	= 0 = -	it.	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281	City or Town, S	et and Number or Rur State)	al Houte Number,
	urs a						
	Hosp 4 ho Fune Bly f	edical	29a. Certifier (Check only age) Medical Examiner: On the basis of examination and/or investigation, in my opinion and/or investigation, in my opinion	late and place, and on, death occurred	due to the caus	se(s) and manner as a	stated.
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director; completely filled in by the	Med	and mainer stated.				
L	To To	-	29b. Signature and title of certifier 29c. License nur			. Date signed (Month,	
•	101		I chumtere leporto MD 6150	7 7	J	une 10"	7005
	2541		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	5		Christine Lepoutre, M.D. 9901 Medical Center D	rive, Ro	ckville,	, Maryland	20850
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	JUN 1 3 2005 Keeper & Species				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar			iale c	n Ivia	rytariu /			te of			ieritai i iy	Reg. 1			10700
			Decedent's Name	(First, Middle	e, Last)									2. Date of De	ath	400	J	3. Time of Death
	Physici				Г	oral	96			Tne	singa	9		June	8,		/ear	1:52 A M
	/Medic Examin		4a. Facility Name (II	not institution									of Death	Julio		4c. County of		1.32 A
	Examin	eı	Stella					ar.		· .	owsoi				-	Bal	time	ore Co.
	Funeral		5. Social Security No		6. Sex			(In yrs. last b.	irthday)	If Unde	er 1 Year	If Unde	r 24 Hrs.	8. Date of Bir	th .	_		lace (State or Foreign
	Director		220-22-8 Usuel Residence of	995	1 □ M	2 ⊠ F	78	3	Yrs.	Months	Days	Hours	Min.	June 1		1926	Mar	yland
	and wo		10a. State	10b. County				10c. City, Tov	wn or Lo	cation							1	0d. Inside City Limits
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	h the Maryland r 28a-f show chotilled st	Director	Maryland 10e. Street and Nun		Balti	more				10f. Zi	p Code	.		Dunda		Citizen of Wh	at Coun	try?
	ath with 23s or ust be	₫											2122	22		nited		,
	eath	Funeral	11. Marital Status	Guy Wa	-	Was Dec	edent E	ver in U.S.	13. \	Nas Dece	edent of H	lispanic C				14. Race		
4.0	ter d	Fu	1 Never Marrie	ed 2□ Marı		Armed Fo 1 ☐ Yes	orces?		1	f Yes, spe	ecify Cuba	an, Mexic	an, Puerto	ecity Yes or No Rican, etc.)			White,	
336	ours after dea al', or itema Examinar m	þ	3√2 Widowed			If Yes, Gi Year or D	ve		'	1 🗆 Yes	20 No	Specif	y:			Specify:	1	White
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21	e filed within al Hygiene. I other then " vent, Ine Ma	S	8 Years						Hom	emak	er					Own I		
pu	al Hy d oth	Be	17. Father's Name (First, Middle,	Last)									e (First, Middle,				
<u>yla</u>	Meni Meni Meni Meni Meni Meni Meni Meni	၉	Harry	D.	Воус								Nell:			Dellir		
, Maryland	es I and 2 should be tiled within of Health and Mental Hygiene. If Item 27 is marked other then " ir other traumatic event, the Mes		19a. Informant's Na Mrs. Dor				augh	nter)	19	75 Gt	uy Wa	ay D		al Route Numb lk, Mar			ate, <i>Zip</i> .222	Code)
ore	Mrs. Dorothy Burford (Daughter						20b. Place o	of Dispo	sition (Na	me of other plac	ce)	[Date	20c.	Location - C	ity or To	wn, State	
Ĕ							Garde	ens (of Fa	aith	Cem	6/2	10/2005	R	oseda1	.e, 1	Maryland	
Baltimore,	permit. Departi		21. Signature of Fu	neral Service	Licensee				22 D	Name a uda –	nd Addre Ruck	ss of Fac Fune	ral E	Home of	Du	ndalk,	In	c.
	90E 9 9		~OE		>_				79	922 W	lise_	Ave.	Dur	dalk, N	Mar			222
			23a. Part 1. Enter the shock, or hear	ne disease, or t failure. List	only one of	ons that of	aused to	the death. Do e.	not ente	er the mo	de of dyin	ig, such a	s cardiac (or respiratory a	rrest,			Approximate Interval Setween
	Physician		Immediate Cause (disease or condition	Final 1		REN	AL F	AILURE	:									Onset and Death
4	/Medical		resulting in death)					consequence										
	Examiner		Sequentially list con	nditions.	b			NSION										
7	P #	Inel	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate rlying	Į	Due to	(or as a	consequence	of):									
V	and and Il-trans	Examiner	that initiated events resulting in death) L		c	Due to	(05.00.0	consequence	n4\:									
50,	death certificate be executed e attending physician and d for use as the burral-transit		, , ,		l	D06 10	(OI as a	consequence	01).									
68760	cate b	Medical			d													
_	entific fing p		IF FEMALE:		220	If use ou	tooma o	f oroganous						·		-		
Вох	eath cer attendir for use	lan/	23b. Was decedent in the past 12	months?		1 Live b	oirth 2	f pregnancy : Fetal deatl			regnancy	,				23d. Date of Month		ry Day Year
0.	the a	Physician/	1 ☐ Yes 2 ☑ 9 ☐ Unknown	No		4∐Pregr 9☐Unkn		me of death	5 🗀	Other (s	респу)							
<u>α</u>	that the dended by the second		Part II. Other signifi	cent condition	ons contrib	uting to d	eath hut	not resulting	in the ur	nderlying	cause niv	en in Part	1	23e. Did t	ohacco	use contrib	ute to th	e cause of death?
ecords,	0 0 0	by	Tarrii. Striot digitii		one contrib	oung to a	out., pot	. not robbiting	iii (iio gi	idonyang i	oudso giv	OIT IIT I GIT	••					ably 4 X Unknown
orc	v requii	etec												-				. 4
ec	2 2 2	Completed												24a. Was autop	osy	24b. We	re autop	sy findings available apletion of cause of
Vital R	That are	S												1 ☐ Yes	rmed?	10 1	Yes	2 🗆 No
/ita	ysician: The is certificate director, pag	Be	25. Was case referr examiner?		-	sital:					0*			(Check only o				
of	Physician: this certific	2	1 Yes 2 X		Hosp	1 🗆		1 2 ER/O				4 🗆 1						HOSPICE
n o	Ing Viter une	on	 Manner of Death Matural 	5 Pendin	9	28a. Date (Mon	th, Day	Year) 28b.	Time of Injury		28c. Injun Worl			28d. Describe h	now inj	ury occurred		
sio	Attending r death. ector: After	cat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be					М		Yes 2		006 1	C4 1			
Division	or At after of Direct in by	Certification:	4 Homicide	determ				y - At home, f. (Specify)	arm, stre	eet, factor	y, office		1	City or Tov			or Hurai	Route Number,
_	spital nours neral		29a. Certifier	1X Certifyin	g Physici	en: To the	best of	my knowledg	e, death	occurred	at the tin	ne, date a	nd place,	and due to the	cause(s) and mann	er as sta	ited.
	To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the fi	edical	one)	1		On the b and man	asis of e	examination are ed.	nd/or inv				ath occurr	ed at the time,				
	To To I	Σ	29b. Signature and	title of certifi	r					29	c. License	e number	0 -		29d. D	ate signed (Month, E	Pay, Year)
•				0/	-:-						<u> </u>	4.3	112	i		6/8	10.	5
	10		30. Name and addre					ath (Item 23a)			RD -	ттма	MITM	, MD 21	Vos			
	Sta		31. Date filed (Mont	h, Day, Year)		32. F	legistrar	's Signature					ZALLUIT.	, 1111 <u>2</u> 1	uJ.)			
	Registr	ar		JUN .	13 21	JUD	Sept.	un B	X A	1004	U							

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Amend Item 18 per verb from inf 8844 6-23-05 vt

State of Maryland / Department of Health and Mental Hygiene

		_	_ State	State of Ma	-	artment of F		and Mental Hy			
	Physicia /Medic		1. Decedent's Name (First, Middle, Last CLARENCE	JOHN		runcate or	Jean	2. Date of De Month		905 2005	в. Тупе о Певати 12:30 р м
	Examin	4.1	4a. Facility Name (If not institution, give HARBOR HOSP		ENTER	4b. City, Town, o BALTI		_	4c. Co	unty of Death	
	Funeral Director		5. Social Security Number 6. S		e (In yrs. last birthday Yrs.		If Under Hours		ıy, Yəar)	Coul	place (State or Foreign ntry) 1 and
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					Od. Inside City Limits
	e Many Se-f sh tiffed	ctor	Md N/A		Baltimore						1 No 2 No
	with th	Funeral Director	10e. Street and Number 2913 Rayshire Roa	a		10f. Zip Code 21230				of What Cou	ntry?
	death ms 23	neral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Decedent of H	ispanic Ori	gin? (Specify Yes or No	U.S.,	Race - America	
980	72 hours after death with the Maryland neturel', or Items 23s or 28e-f show diest Everninet rust be rediffed at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ ₩		ĭ, Puerto Rican, etc.)	Sp	Black, White, ecify:	
5-0036	s 1 and 2 should be filed within 72 hours f Health and Mental Hygiene. item 27 is marked other then "neturel", other traumatic event, the Madical Eve	Completed	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Occup e kind of work done	during mos	t of working	16b. Kind	of Business/In	
2121	filed within Hygiene. other then " ent, the Me	duc	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired auffeur	2)		City	Sanita	tion
	e filed al Hygie other vent, II	Be Co	17. Father's Name (First, Middle, Last,)			18. Mothe	er's Name (First Middle Willie	Maiden Su		nelps
Maryland	should be fund Mental I	To E	Walter Johnson					llie Philes			
Mar	d 2 sho th and I to ma trauma		19a. Informant's Name/Relationship (Mary Johnson	Type, Print)	1200			er or Rural Route Numb	6877	200 90	21230
	ges 1 and 2 t of Health if item 27 or other tr		20a. Method of Disposition		20b. Place of Disc	3 Rayshir position (Name of ematory or other place		d Baltimor	20c. Locat	ion - City or T	own, State
imo	Pages ment of h ant: If its ury or of	H	1 Sourial 2 Cremation 3 C 4 Donation 5 Other (Specif	ý)	Mt Zion			06-21-2005			Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Liger	nsee				Wise Funer 1d Ave Bal			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that cause one cause on each li	ne.			WORDS COLVERNI	rrest,		Approximate Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	a. TERM Due to (or as	a consequence of):	UNG	CAN	ICER		-	1 year
	Examiner		Sequentially list conditions,	b. POSTO	BSTRUCT	ION PI	YEUI	MONIA			9 days
(led sait	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	a consequence of):	- ATTI	507	ASIS OF	1120	6	9 days.
oʻ.	be executed sician and burial-transit		that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	FILECE	C/1	13/3 0	2001	a	
8760,	cate be ex physician a the burial	dlcal	(d						-	
Box 6	ath certifi attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant a	2 Fetal death 3	☐Ectopic pregnancy	/		23d	. Date of deliv	ery Day Year
P.O.	that the de ed by the a detached	hys	9 🗌 Unknown	9 Unknown							
	w requires that been signed I should be det	ed by	Part II. Other significant conditions of ACUTE RE		_		en in Part I				he cause of death? pably 4 Unknown
Division of Vital Records,	The law requ ite has been bage 2 shouk	Completed by	HYPERTENS	SION				24a. Was auto perfo		prior to co death?	ppsy findings available impletion of cause of 2 No
/ita	cien: ertifica ector, I	Be	25. Was case referred to medical examiner?	Unanitali		Oth		of Death (Check only			
of	Physi r this c ral dir	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1 🔀 Inpati 28a. Date of Inju (Month, Da				ursing Home 5 Resi			(y)
ion	nding ath. r: //te e fune	ation	1 Natural 5 ☐ Pending Accident investigation		ay Year) Injury		k? Yes 2□	No			
Divis	after des	Certification:	3 Suicide 6 Could not be determined	200. Place of III	jury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office			Street and N wn, State)	lumber or Rur	al Route Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Di ector: After this certificate ha completely filled in by the funeral director, page	edical C			of examination and/or			nd place, and due to the tth occurred at the time,			
	To th within To th compl	Me	29b. Signature and title of certifier	-P		29c. Licens		614829		igned (Month,	
	3		30. Name and address of person who DR · KARUNA PO	completed cause of	death (Item 23a) (Type 3001 SOUT	D :		STREET, BA			
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 3 200	32. Regist	rar's Signature	refe					

DHMH 17 Rev 1/2001

05-03916 Lawrence Johnsonamend item#21, perFit. DVR, G844, 6/14/05 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 **Physician** Johnson Lester Lawrence /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 10 25 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months XXM 2□F 10 PÃ Director 44 215-86-1937 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Itams 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic avant, the Medical Examiner must be nutified at MD NA Baltimore ty∏yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3832 Roland View Ave 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X XNo Specify: Specify. Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Laborer Baltimore City na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rose Johnson Chalmas Johnson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 North Highway #501, Marion, SC 29571
ace of Disposition (Name of Date 20c, Location - City or Town, State other Rosa Mays-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 permit. Page Department of Important: If any injury or once. 6/16/05 Baltimore Co, Md Woodlawn 22 Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee Lynette Jones per DVR 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OHLE ST disease or condition resulting in death) GUNSHOT WOUND 20 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) O 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 2 No Division of Vital Be director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation SUBJECT WAS SHOT 61 7/05 11:37 PM 1 ☐ Yes 2 🔀 No death. 2 Accident after death Director; the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 3832 KOLYAND VIEW, BALTIMOREMO within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number June agned Mont Day, Year) OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Penn Street 0 Baltimore, Maryland 21201 KNB101 ANA 31. Date filed (Month, Day, Yea) 20 Begistrar's Signature

State

Registrar

parte

			1 - For State Registrar	State of Ma	aryland			of Health a of Death	and Me		jiene (005	19583	3
			Decedent's Name (First, Middle, Las	")			·			2. Date of Dea			3. Time of Death	h
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			Shady Grove Adver			ast birthday)	If Under 1 Y		24 Hrs	8. Date of Birth			-	- in-
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	Director		579-04-3833						<u> </u>	sept. 2		0 511	Бапка	
	and and		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Lim	nits
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	s 23	ral	18705 Sparkling Wate						=:=2 /0===					
	er de	m	11. Marital Status	12. Was Decedent Armed Forces?			Yes, specify	of Hispanic Orig Cuban, Mexican	n, Puerto R	ican, etc.)	14	Race - Ame Black, White	e, etc.	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ! If Yes, Give Year or Dates:	40		∏Yes 2Д	No Specify:			s	pecity:	ian	
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$\frac{3}{5}$	d Mer nark	٦	Pandu Waduge Juani			405 44-115-	- 111 (01				_	_		
Maryland 2121	12 st		19a. Informant's Name/Relationship (7			190. Mailin	Coordeld	ng Water 1	Design	Ant #1	City or i	own, State, 2	Zip Code) 20874	
d)	as 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I have marked other than "natural", or Items 23a or 28a-f show it othar traumatic evant, the Medical Examiliator was be notified at		Malini Jayasekera 20a, Method of Disposition	/ WITE	20h Pl		sition (Name of		DITAG			tion - City or		
altimore,	permit. Pages 1 Department of H Important: If ita any injury or ott		1 Burial 2 Cremation 3	Removal from State	ce	metery, cren	natory or other	place)	June	12,		11.		
트	Pa men ant: ury		`4 □Donation 5 □ Other (Specify		1 _m g _n	emator	Yum, I	nc.	20	05]	Bethe	sda, M	laryland	
Ö	apart aport ny in		21. Signature of Funeral Service Lic-			Be	. Name and A	ddress of Facility	zRo e Chase	rt Inc.	7557	rey Fu Wisco	neral Hom	€/
<u> </u>	205 2		Much]	M0135	3 $B\epsilon$	thesda	, Maryl	and 2	.0814-3	001			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each li	the death	. Do not ent	er the mode of	dying, such as	cardiac or	respiratory arr	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	7777.4	ocar	4 4		arction					Onset and Death	
	/Medical		resulting in death)	Due to (or as									2043	
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o`	exer an ar rial-t	EX	resulting in death) Last	Due to (or as	a consequ	ence of):								
8760	cate be executed physician and the burial-transit	dical		d										
9	tifica ig ph as th	o o									-	-		
Вох	eath certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			Ectopic pregn	2001			23	d. Date of deli	very	
	death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at			Other (specif					Month	Day Year	
0	The law requires that the death certifi te has been signed by the attending l age 2 should be detached for use as	Physician/M	9 🗆 Unknown	9□ Unknown						-				-
U.	res tha igned be det	by P	Part II. Other significant conditions of	entributing to death b	ut not resu	lting in the ur	nderlying caus	e given in Part I.	•	23e. Did to	oacco use	contribute to	the cause of death?	
ğ	quire n sig uld b		anemia							1 □ Y	es 2□	No 3∏Pro	obably 4 🗷 Unknov	wn
္ပ	w require s been sign should t	lete	ovlmonary edi	21000						24a. Was a	n	24b. Were au	topsy findings availal	ble
æ	The lay	Completed	11 /	W.G.						autops perfori	ned?	prior to death?	completion of cause of	of
Vital Records,			dia betes 25. Was case referred to medical					00 81	of Dooth	1 Yes		1 Li Yes	2□ No	
⋚	ysician: is certific director,	o Be	examiner?	Hospital:		TD/Outpotion	t 3□ DOA	Othor		(Check only on e 5 ☐ Reside		70**** (0		
ō	Phys r this ral di	Η,	27. Manner of Death	28a. Date of Inju		28b. Time of		Injury at	-	d. Describe h			ату)	
0	ding Ph h. After th funeral	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Da	y Year)	Injury		Work? 1 ☐ Yes 2 ☐ I	No					
S	Attanding Physician: r death. ector. After this certifics by the funeral director.	fica	3 Suicide 6 □ Could not be		urv - At hor	me, farm, str	eet factory of	fice	28	3f. Location (Si	reet and i	Number or Ru	ral Route Number,	-
Division of	a Hospital or Attano 24 hours after deatl a Funeral Director: etely filled in by the	Certification:	4 ☐ Homicide determined	building, et	c. (Specify,)	,,,			City or Town			,	
	spita ours neral filled	C	29a. Certifier 1 Certifying Ph	sician: To the best	of my knov	vledge, death	occurred at the	ne time, date and	d place, ar	nd due to the c	ause(s) ar	nd manner as	stated.	
	To tha Hospital or A within 24 hours after To tha Funeral Direction Completely filled in by	edical		iner: On the basis o and manner st	f examinati	ion and/or inv	estigation, in	my opinion, deat	th occurred	d at the time, d	ate and p	lace, and due	to the cause(s)	
	ompl	Me	29b. Signature and title of certifier	. 1			29c. Li	cense number	/ / ^	2	9d. Date :	signed (Month	n, Day, Year)	
)	. > - 0		1 Charact la	soll	141	0		615	79		丁し	ne 1	0,2009	5-
	. 6		30. Name and address of person w o	completed cause of c	leath (Item	23a) (Type	Print)	,	,			. /		
	10		Constine	Lepou	2	, (1) [2]	-,	Shad	dy	Grove		Hospit	60, 2009 fal	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr			1					-1		
	Registr		JUN 1 3	2005 Nome	Page a	B. L	Caste							

	q		1 - For State Registrar	State of M	aryland / D		ent of H		Mental Hy	/gieno Reg. No	2111)5 1	9581
	Physici	ion	1. Decedent's Name (First, Midd	lle, Last)					2. Date of D Month	eath Da	av Ye		of Death
	Physici /Media			Robert Kish							2005	2:00	Рм
	Examir	ner	4a. Facility Name (If not institution	n, give street and number,	1	4b. (City, Town, or	Location of Dea	th	40	c. County of I	Death	-
			Charlotte Hall					te Hall			aint N		
ŀ	Funeral Director		5. Social Security Number 579-52-4024	6. Sex 7. A	ge (In yrs. last birth 75 Y	Mon	ths Days	Hours Min		ay, Year,	9. 929 N	Birthplace (State Country) ew Jersey	e or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town	or Location						10d. Inside	City Limits
	Mary -fah	ţ	Flordia Duval		Tack	sonvil	16					1 □ Ye	es 2XXNo
	death with the Maryland ms 23a or 28a-f ahow Litust be rediffed at	Director	10e. Street and Number		5001		. Zip Code			10g. Ci	itizen of Wha	t Country?	
	th with		13245 Atlantic Blv	/d. #243			32225			1	USA		
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was D	ecedent of H	ispanic Origin? (S n, Mexican, Puer	Specify Yes or N	0-		American Indian, Vhite, etc.	
0000	in 72 hours after death with the Marylan "natural", or Items 23e or 28e-f ahow tedical Exertine must be multified at	by	1 ☐ Never Married 2 ☐ Mar 3 🖾 Widowed 4 ☐ Divorced	rried 1 X Yes 2			s 2 No	Specify:	to though oto.y		Specify:		
	"natu	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		Give kind o	Jsual Occup	turing most of wo	nrking	16b. K	Kind of Busin	ess/Industry	
٧	with ene.	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	mmunica	Tuse retired)		II C	. Gover	nmant	
V	filed Hygi other ant, I		17. Father's Name (First, Middle,	Last)	00	IIIII GITLE	at Tolls	18. Mother's Na	me (First, Middle			illient	
<u>a</u>	0 5 0 0	To Be	George Leezo						h L. Kish		ŕ		
2	s 1 and 2 should be f Health and Mental itam 27 is marked o othar traumatic ev	-	19a. Informant's Name/Relations	ship (Type, Print)	19b.	Mailing Add	ress (Street	and Number or R		oer, City	or Town, Sta	te, Zip Code)	
<u>a</u>	rt 1		Barry Kish / Son		132	45 At1a	antic Bi	Lvd. #243,	Jacksonv	ille,	Flordia	a 32225	
Çe,	of Hea of Hea litam		20a. Method of Disposition	2	20b. Place of I			0)	Date une	_		or Town, State	
Ĕ	Pages nent of ant: If it ury or o		1 Durial 2 Dremation 4 Donation 5 Other (5		Metropol			1 0	2005	Alexa	andria,	Virginia	
Dalitimor	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funer vervice	Licensee			e and Addres	The second second		. P	Δ		
_	20529		Tyle	Jamen		P.O. 1	3ox 270.	Leonardt	own, Mary	land :			
4	Priysician		23a. Part. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	t only one cause on each l	a consequence of							Approxim Interval B Onset an	etween
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of): '	/	A 1		10	98	/1-	-4
		<u>.</u>	Sacuantivity list conditions	b. Ceve	600vas	Cu (ar 1	reide	nt wi	th	Left	Hemi	olegia
v	ited nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	14.	La sonsoquence on	2115	ion						
	be executed ician and burial-transit	Exal	that initiated events resulting in death) Last	C. Due to (or a	a onsequence of			,					
-	ysicia e bur	call		d.								Į.	
0	certifical	led	15 551111 5										
O. DOX	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death	3 ☐Ectop 5 ☐ Other	ic pregnancy (specify)				23d. Date of Month	delivery Day	Year
ŗ	that ned by deta		Part II. Other significant conditi	ons contributing to death t	out not resulting in t	he underlyi	ng cause give	on in Part I.	23e. Did	tobacco	use contribut	e to the cause of	death?
2	quires nn sign uld be	ed by	Colon Ca	mcer S/	P Co	ost	omy	1	1 🗆	Yes 2	19No 3	Probably 4	Unknown
SDIOSA	s bee	Completed	Bilateral	Staghorn	Calcu	lus		7	24a. Was		24b. Were	autopsy finding to completion of	s available
	sician: The law s certificate has b lirector, page 2 s	mo								ormed2	deat	1?	cause of
VICA	lan: rtifica stor, p	0	25. Was case referred to medica	ıl				26. Place of De	1 ☐ Yes ath (Check only		, , ,	Yes 2 No	
>	Physician: r this certifica ral director, I	To B	examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/Outp	atient 3	DOA Othe		lome 5 ☐ Resi		6 ☐Other (5	Specify)	
5	ding Physician: The		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of Inju (Month, Da		ne of	28c. Injury Work	at	28d. Describe				
200	Attanding or death. ector: After by the fune	catle	2 Accident investi	igation		M	10,	res 2□No					
Ž	al or Att s after de il Direct od in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of In	iury - At home, fam ic. <i>(Specify)</i>	street, fac	ctory, office		28f. Location (City or To			r Rural Route Nu	mber,
	To tha Hospital or Attandi within 24 hours after death. To tha Funeral Director: A completely filled in by the to	edical (29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	if examination and/	death occur or investiga	red at the tim tion, in my op	e, date and place inion, death occu	e, and due to the urred at the time,	cause(s)) and manne d place, and	r as stated. due to the cause	(s)
	To th withir To th comp	Me	29b. Signature and title of certifie	or of			29c. License					onth, Day, Year)	
			Parel	Sani	nw		D45	5092		51	/31/	05	
	,1		30. Name and address of person		death (Item 23a) (T	ype, Print)				e d	du satella		:=
	10		110 Hospitan		Suite 7	420	5, P	vince	fredu	ich	M	D 200	678
	Sta Registr		31. Date filed (Month, Day, Year)	2005	ar's Signature	alle)					•		

DOB 10/7/29

Robert Kish

Time of Death: 5/30/05 &pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 1:42P. M 2005 June Leona Kulinski /Medical 4a. Fecility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner <u>Johns Hopkins Hospi</u>tal Baltimore n/a Months Days Hours Min. April 1, 1914 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Months 216-28-2818 91 Maryland Vrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c City Town or Location 10a State 10h County 10d. fnside City Limits or 28a-f show other traumatic event, the Medical Exercities must be notified at 1 Yes 2 No Director Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 South Wolfe Street 21231 USA itа⊞s 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Specify: 3 XWidowed 4 ☐ Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Heant: If item 27 is marked oth jury or other traumatic even Be John Zubrowski Lillian Ceslewicz 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Kulinski/daughter 9395 Harritt Rd, Space96, Lakeside, Calif92040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem 6/13/2005 Baltimore, Md. permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cav O mille /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 XNo Month Vear 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ➡ No 24a. Was an autopsy performed? 2 No 2 No 1 Yes Hospital or Attanding Physician: ours after death. naral Director: After this certifica filled in by the funeral director, I 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No Hospital: 2 ER/Outpatient 1 🗌 Yes 1 🗌 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

31. Date filed (Month, Day, Year) State Registrar

Finu cane Hopkins 32. Registrar's Signature

5505

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

June 10, 2005

Bayview Circle, Baltimore MD

21224

			Please	Type or Prin							Legible.	
			For State	State of Ma	aryland	-	ırtment of <i>tificate c</i>	Health and	Mental Hy		000	
			Registrar 1. Decedent's Name (First, Middle, La	st)	_		imeate e	Dodin	2. Date of D	Reg. No.	400	3. Time of Death
	Physicia		Sophie	Alice		ŀ	Kowale	wski	JUNE	08,	2005	4:55 AM
	/Medic Examin		4a. Facility Name (If not institution, giv		,		•	, or Location of Deat		4c.	County of Death	
			Good Samanita					more	1.5. (0)		IA	
	Funeral Director		5. Social Security Number 6. S 218-05-3248	ex 7. Age □ M 2ŽÍF	85	Yrs.	If Under 1 Ye Months Day			, 191	9 Mar	place (State or Foreign ntry) yland
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	Maryl	tor	Md n/a			B.	altimo	re				1X Yes 2 No
	h the	irec	10e. Street and Number				10f. Zip Cod			10g. Citiz	zen of What Cou	ntry?
	23a c	aiD	4411 Anntana	Avenue			2	1206			USA	
	er de de de de de de de de de de de de de	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puer	pecify Yes or N to Rican, etc.)	0- 1	 Race - Ameri Black, White 	
36	irs aft		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10	1	☐ Yes 2☐X	lo Specify:			Specify: Wh	ite
Š	should be filed within 72 hours after death with the Maryland di Menal Hygiene. marked other than "natural", or liems 23a or 28a-f show marked other than "natural", or liems 23a or 28a-f show marke ovent, the Medical Examinar mant be notified at	Completed by	15. Decedent's E (Specify only highest gra		1	16a. Deced	lent's Usual Oc	cupation ne during most of wo	dkina	16b. Kir	nd of Business/Ir	ndustry
2	ne. han "u	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	OO NOT use ret	ired)	.Kiirig	ļ ,	avern	
2	filed v Hygie ther t	C	12th 17. Father's Name (First, Middle, Last)		OWI	ner	18. Mother's Nar	ne (First, Middle			
aŭ	ed all be	To Be	John Topa						Pancak		,	
Maryland 21215-0036	2 should be and Mental Is marked of aumatic eve	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Stre	et and Number or Ru	ıral Route Numb	ber, City or	Town, State, Zi	Code)
	- C & 5		<u>Anna Reavis (da</u>	aughter)				na Ave.				
Baltimore,	0 0		20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐		cem	etery, cren	sition (Name of natory or other p	lace)	Date		cation - City or T	
	permit. Page Department (Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licer		поту	y KO:	sary C					Home, PA
Ba	Depi Impo		Led the	Ian X				ndalk Av				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ente	er the mode of o	lying, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Coron	ary	4 1		Disease				Onset and Death
ı	/Medical Examiner		resulting in death)	Due to (or as	a consequer		/					
		er	Sequentially list conditions, if any, reading to immediate	b. — Dua to (or as	ă ourisequei	ice of).						
	executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
Ö,	- 0 -		resulting in death) Last	Due to (or as	a consequen	ice of):						
9/89	The law requires that the death certificate be the has been signed by the attending physici age 2 should be detached for use as the bu	Physician/Medical		d								
Box	certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	3d. Date of deliv	ery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregna Other (specify)				Month	Day Year
J.	res that the de signed by the a be detached i	Phys	9 Unknown						00: Pil			
	ires th signed	by	Aortic Steine	-	ut not resultir	ng in the ur	iderlying cause	given in Part I.		Yes 2	/	he cause of death?
Records,	v require been sig should b	Completed		ilation					24a. Was			opsy findings available
	The lav	ошо	Gastrointestin	· · · · · · · · · · · · · · · · · · ·	j				auto	opsy ormed?/	prior to co death? 1 🗆 Yes	mpletion of cause of
Vital		Be C	25. Was case referred to medical	Ten Brece				26. Place of Dea	1 Yes	2 No	1 1 105	20110
ot <	Physician: r this certifica ral director, I	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		/Outpatien	3 DON				□Other (Speci	fy)
	ding Ph After th funeral	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28	Bb. Time of Injury	V	jury at vork? □Yes 2 □No	28d. Describe	how injury	cocurred	
Division	after death Director: In by the	ficat	2 Accident investigatio 3 Suicide 6 Could not be determined	One Diese of Inju	ury - At home	e, farm, stre						al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	4 Homicide	building, etc	c. (Specify)				City or To	wn, State)		
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical (29a. Certifier 1 Certifying Pl	nysicien: To the best on miner: On the basis of	examination	dge, death	occurred at the	time, date and place	a, and due to the	cause(s)	and manner as s	stated.
	To the P within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner sta	ited.			nse number			signed (Month,	
	N N N		1/2/	lon	n	20		5 778 7	7			,2005
	al		30. Name and address of person who	completed cause of d		-	Print)	. , , , ,		J -(, - 0 5
r			000	00 5601 0	och	Rav	en Bl	vd, Bai	timo.	re,/	110 2	1239
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	ar's Signatur	for	de	vd, Bai				
	negisti	004	701/ T 9 C	Julian		1	-					

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			1 - State of Ma	aryland / Depa		of Health ar of Death	nd Menta	al Hygien Reg. N	2000	19587
	Physici	an	Decedent's Name (First, Middle, Last)				Mo	te of Death	ay Year	3. Time of Death
	/Medic	al	Diane R. Leroy	•			Jur		2005	11:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 3215 Fox Glove Lane			wn, or Location of			c. County of Death	
	Funeral			(In yrs. last birthday)	If Under 1			te of Birth	altimor	olace (State or Foreign
	Director		213-42-4126 ^{1□M 2} \$\footnote{2}\footnote{2}	62 Yrs.	Months [Days Hours	Min. Aug	te of Birth onth, Day, Yea J. 14, 1	942 Mar	yland
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	neation					0d. Inside City Limits
	Aaryla f sho	ō	MD Baltimore	,,	ddle :	River				1 ☐ Yes 34 ☐ No
	the 1	Director	10e. Street and Number		10f. Zip C			10a, C	itizen of What Cou	
	death with the Maryland ms 23a or 28a-f show Livast by rediffed at		3215 Fox Glove Lane		21	220		US		•
	ems 2	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	ver in U.S. 13.	Was Deceder	nt of Hispanic Origin Cuban, Mexican, I	n? (Specify Ye	es or No-	14. Race - Ameri	
2	or It	by Fu	1 Never Married 2 Marned 1 Yes 2011	lo	1 ☐ Yes 2 ☐		r derio i nodni,	610.7	Black, White, Specify:Whi	
ე-იიკი	n 72 hours after death with the Marylan "naturel", or Items 23e or 28e-f show solical Evanil, ar Iransi be notified at		3 ☐ Widowed 4X Divorced Year or Dates: 15. Decedent's Education	162 Dogg	dont's Heuri	Desupation		105		
Ċ	n "na	plet	(Specify only highest grade completed)	(Give	dent's Usual (kind of work DO NOT use	done during most o retired)	of working		Kind of Business/In	
7	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5 2yrs	Lab	Tech			B	lue Shei	ld
and		Bec	17. Father's Name (First, Middle, Last)					Middle, Maide	n Sumame)	
<u>X</u>		To	Frank Adam Rinkers			Mae	Schut	z		
Mar	12 sho h and 7 Is m		19a. Informant's Name/Relationship (Type, Print)					-	or Town, State, Zip	
a)	is 1 and 2 should of Health and Mer item 27 Is marke other treumatic		Frank A. Leroy /son 20a. Method of Disposition	20b. Place of Dispo	sition (Name	x Glove	Date		Location - City or To	21220
altimor	00		1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bayview	natory`or othe Crema	atory	1 [- W	timore 1	
	antra orta inju		21. Signature of Funeral Service Licensee			Address of Facility	11-1			
Ď	Dep fining yrs		* R Terry Cons	relly	300	Maco At			neralHom re_MD 21	eofEssex
		(t1)	23a. Part. Enter the disease, or complications that caused shock, or heart failure. List on the cause on each line	the death of ent					e mu zı	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	condial	infa	1 Ction				Onset and Death
	/Medical Examiner		resulting in death)	consequence of):						- COICA
	LAditiiilei	<u>.</u>	Sequentially list conditions, b. Due to for as:	consequence of):	levole	ma				tun
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	consequence or):	00.4					
,	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last C. Ut CU2 Due to (or as:	consequence of):	MIT	W				jeais
00/9	icate be executed physician and s the burial-transit	dical	d							
0	certifical Iding physe as the	a)	IF FEMALE:							
6	death ce e attendi ed for use	hyslcian/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 □ Live birth		Ectopic preg	nancy			23d. Date of deliver	*
5	the a	/slci	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (speci	ify)			WOITH	Day Year
	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as	0	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cau:	se given in Part I.	23	e. Did tobacco	use contribute to the	ne cause of death?
Hecords,	uires n sign lid be	d by	Hugertension					1 Tes 2	No 3□Prob	ably 4 Unknown
5	w requir s been si should	Completed	//				24:	a. Was an	24b. Were auto	psy findings available
r v	: The law cate has I	omp						autopsy performed?	prior to con death?	npletion of cause of
		O	25. Was case referred to medical			26. Place of	f Death (Chec	Yes 2ÆN k only one)	1 ☐ Yes	2□ No
> 5	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	it 3□ DOA	Other: 4 Nursi	ing Home 5	Residence	6 Other (Specify	')
<u> </u>	ding Phys h. After this funeral dir	on:	27. Manner of Death 17 Natural 5 □ Pending 28a. Date of Injur (Month, Day	Year) 28b. Time of Injury		. Injury at Work?		scribe how inju	iry occurred	
Mision	ttend death tor: /	ertification:	2 Accident investigation 3 Suicide 6 Could not be	- At home 40-	M	1 Yes 2 No		nation (Caracata	and Alicenter and Com-	15-1-11
2	after Direction by	ertif	4 Homicide determined building, etc	ry - At home, farm, str . <i>(Specify)</i>	eet, ractory, o	пісө	City	y or Town, Stat	nd Number or Rura e)	i Houte Number,
	spite	alC	29a. Certifier Ma Certifying Physicien: To the best of	f my knowledge, death	occurred at t	the time, date and p	place, and due	to the cause(s	and manner as st	ated.
	To the Hospitel or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or invited.	vestigation, in	my opinion, death	occurred at the	e time, date an	d place, and due to	the cause(s)
	To T	\$	29b. Signature and title of certifier	_	29c. L	icense number		29d. Da	ate signed (Month,	Day, Year)
1	5		MAKMIN MD.	Physic	ian	D00600	588	4	113/20	05
X	1		30. Name and address of person who completed cause of	eath (Item 2 a) (Type,	Print)	DOOGOO	ĥaca	145	717 - 1	
ď	Sta	te	31 Date filed (Month Day Year) 32 Regist	15 20040 rs Signature	in bl	vo. Dal	ILVIVIOLE	1 / ///	LILLI	
	Registr		JUN 1 3 2085 D	Mur S.	Coard	ال				

		•	For State		State of I	Maryland	-	artment of H			-	-000	19588
			Registrar 1. Decedent's Name (First	st. Middle, Las	it)			tineate of t		2. Date of De	Reg. N	0.	3. Time of Death
	Physici		Steven		Loucas					June		ay Year 2005	11:00am
	/Medio Examir		4a. Facility Name (If not in			er)		4b. City, Town, or	Location of Death			c. County of Death	
		Ξ'	945 Lance	e Road	f			Essex			E	Baltimo	re
	Funeral Director		5. Social Security Number 215-46-72		9x 7. X M 2□ F	Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da Jan. 4	rth ay, Year	9. Birth MAr	place (State or Foreign intry) Yland
	P .		Usual Residence of Dece										
	arylar show	Ļ		.County altimo	220		Town or Lo						10d. Inside City Limits 1 Yes 2 30
	8a-f	cto		arcino		1	ssex						
	h with th	Funeral Director	10e. Street and Number 945 Lance	e Road	f			10f. Zip Code 2122	1		10g. C	itizen of What Cou SA	intry?
	deal ems	ner	11. Marital Status		12. Was Decede		. 13.	Was Decedent of H	spanic Origin? (Sp	pecify Yes or No	o-	14. Race - Amer Black, White	
036	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent; if item 27 is marked other than "naturel", or Items 23e or 28a-1 show importent; if item 27 is marked other than "naturel", or Items 23e or 28a-1 show apply injury or other treumatic event, tre Madical Exerting must be notified at once.	þ	1 Never Married 2 3 Widowed 4 D		1 ⊠ Yes 2 If Yes, Give Year or Date	□No	1	1 ☐ Yes 2X No	Specify:	,		Specify: Wh	
5-0	72 ho	eted		Decedent's Ed	lucation de completed)		(Give	dent's Usual Occup- kind of work done of	furing most of world	king	16b. I	Kind of Business/li	ndustry
21215-0036	s within jiene.	Completed	Elementary/Secondary		College (1-4 2yr		life.	DO NOT use retired esperso)	9	Bi	ill Car	pet Co.
b	il Hygid other vent, Il	BeC	17. Father's Name (First,	Middle, Last)					18. Mother's Nam	ne (First, Middle	, Maide	n Sumame)	
<u> a</u>	uld be Vental Irked c	To E	Constant	tine	Loucas				Mary .	Angeli	des		
Maryland	and 2 should salth and Men n 27 Is marke ar treumatic		19a. Informant's Name/P Ariana Lo			er		ng Address (Street a					·
စ်	Hear Hear tern		20a. Method of Disposition		daugiie	20b. Pla	ce of Dispo	sition (Name of		Date		Location - City or T	
JOH.	Pages nent of I int: If it		1X Burial 2 □ Cre 14 □ Donation 5 □					natory`or other place thodoxCo		6/10/	05B	altimor	e MD
Baltimore,	parmit. F Departmo Importer eny injur		21. Signature of Funeral			1	22	2. Name and Addres	s of Facility		-17	1 77	CD
ä	Deparmi Depare Impo		X. Ter	rul	muel	Val	4	300				neralho nore MD	meofEssex 21221
			23a. Part1. Enter the dis	sease, or aom	plications that cau	sed the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	1010 111	Approximate Interval Between
	Pnysician	0.1	Immediate Cause (Final disease or condition	,	COR	*		210	an 00	00			Onset and Death
	/Medical		resulting in death)		Due to (or	as a conseque	ence of):	0 10					
8	Examiner		Sequentially list condition	ns,	p. 11 cl	احاك	wo	سيعلما	>				
	sit s	ine	Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ets Z	Due to (or	as a conseque	enecione	. ~ .					
_	xacut and II-tran	Examiner	that initiated events resulting in death) Last		c. Due to (or	as a conseque	ence of):	sen i					
8760,	icate be exacuted physician and s the burial-transit	dical E		l	d								
Box 6		in/Med	IF FEMALE: 23b. Was decedent preg		23c. If yes, outco	me of pregnan		Ectopic pregnancy				23d. Date of deliv	,
P.O. B	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	hs?		t at time of dea		Other (specify)				Month	Day Year
	es that igned b be deta	by Pł	Part II. Other significant	conditions	ontributing to deat	h but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did t	tobacco	use contribute to	the cause of death?
Records,	w require. been sig should b	ted b	-197 K.	6 7	1520	sel	/.			1 🗆	Yes 2	2 □ No 3 □ Pro	bably 4 Hiknown
900	as be	Completed								24a. Was	psy	prior to co	opsy findings available ompletion of cause of
		Con									ormed? 2 ☐ L×	death? 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to examiner?	medical	Mary Hall			0.1	26. Place of Dea	th (Check only o	one)		
of	hysi this c	5	1 Yes 2 No		Hospital: 1 Inp		R/Outpatier		4 LINUISING IN			6 □Other (Speci	fy)
no On		lon		Pending	28a. Date of (Month,	Day Year)	28b. Time o Injury	Worl	rat (? Yes 2 □ No	28d. Describe	now inju	ury occurred	
Division	Attending r death.	ficat		investigation Could not be determined		Injury - At hon	ne, farm, str	reet, factory, office	.03 2010			and Number or Rur	al Route Number,
οŚ	el or A s after N Dire	Certification:	4 🗌 Homicide	determined	building	, etc."(Specity)				City or To	wn, Stat	te)	
	To the Hospitel or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Medical (is of examination		h occurred at the tin vestigation, in my o					
	o the	Se /	29b. Signature and title of	of certifier				29c. License	number		29d. Da	ate signed (Month,	Day, Year)
	1 /		Ne	131	Key	w.	M	NI	ナノしょ	3		15/05	
_	U		30. Name and address o	of person who	010	+ 15	so ch	Print)	مولوم	Ma	Ri	16 Cm	20%
	Sta Regist		31. Date filed (Month, Da	ay, Year) N 1 3 2		jistrar's Signatu	ıre					,	
DH	IMH 17 Rev 1/2	001			1000		T. A.	acele					
							DRIGIN	AL					

			For State Registrar	State of Maryland / Dep	partment of Health ertificate of Deat		Hygiene Reg. No.	A 500 100m	
	o'		Decedent's Name (First, Middle, Last)		2. Date		UUD	3. Time of Death
	Physicia		Rudo1f	Lutz III		June	Day	2005	10:00 p M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Locatio	on of Death	4c. C	ounty of Death	·
	LXdiiiii	٠.	1704 Maryland Av	enue	Shady Side	e	A	nne Aru	nde1
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birthda)	/) If Under 1 Year If Und Months Days Hours	der 24 Hrs. 8. Date of (Mont.)	of Birth	9. Birtho	lace (State or Foreign
	Director		220 - 92 - 2827	MM 2□ F 41 Yrs.	World S Day's Trous	Jan.	1, 196	4 Mar	y1and
5	>		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	agation				0d. Inside City Limits
2	shov	_							1 ☐ Yes 2 X No
2	Se-f	Director	MD Anne Aru	ndel Shady	10f. Zip Code		10a Citiza	on of What Cour	atn/2
dia.	De De	ρ							iuy:
tag	18 23	eral	1704 Maryland Ave		20764 . Was Decedent of Hispanic	Origin? (Specify Yes		USA I. Race - Americ	an Indian.
5-0036 22 hours after death with the Maryland	ital Hygiene. to other then "natural", or items 23e or 28e-1 show event, the Medical Exam in must be notified at	by Funeral	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexic 1 ☐ Yes XXNo Speci	ican, Puerto Rican, etc	:.)	Black, White,	
3 3	atura		15. Decedent's Ed	ucation 16a. Dec	edent's Usual Occupation		16b. Kind	d of Business/In-	dustry
ב ב	n" n	Completed	(Specify only highest grad	de completed) (Giv	re kind of work done during m DO NOT use retired)	nost of working			,
1212	iene.	E	Elementary/Secondary (0-12)	College (1-4or 5+) Sal	es Executive		HV.	AC	
ם ק	Hygi other	Be C	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	18. Mo	other's Name (First, M	iddle, Maiden S	umame)	
Maryland 21215-0036	and Mental F	To B	Rudolf Lutz, Jr.		Del	borah Chal	mers		
aryla	f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (T		iling Address (Street and Nun				
	of Health item 27 I		Kimberley Lutz (W		4 Maryland Ave	enue, Shad	y Side,	MD 207	64
ore	0		20a. Method of Disposition 1 Darial XXCremation 3 D	20b. Place of Dis	position (Name of sematory or other place)	Date	20c. Loca	ation - City or To	own, State
imor Biggi	nent ant: I		'4 □ Donation 5 □ Other (Specify	1	rematory	6/13/2005	Balt	imore,	MD
Baltimore,	Department Important Important: If any injury o		21. Signature of Funeral Service Licens	eral Home, venue, Ann	P.A.	MD 21/4	n 1		
			23a. Part1. Enter the disease, or comp	lications that caused the death. Do not e	nter the mode of dying, such	as cardiac or respirat	ory arrest,	FID 214	Approximate Interval Between
			Immediate Cause (Final		ich car				Onset and Death
	nysician /Medical		disease or condition resulting in death)	aDue to (or as a consequence of):	cvi car	icer		-	> months
E	xaminer								
		ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
Po de la	d d ansit	Examin	cause. Enter Underlying Cause (Disease or Injury that initiated events	c.					
8/60,	physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):					
8760,	ysici ne bu	dical		d					
		Ψ.	15.55141.5					-	
Box	attending p	Physiclan/M	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy		23	d. Date of delive	*
H .	ne att	sicle	in the past 12 months? 1 Yes 2 No		Other (specify)			Month	Day Year
0. 3	ed by the a	hy	9 🗆 Unknown						
Records, P.O. Box 6	s been signed to should be det	by	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Pa	art I. 23e.	1 Yes 2	/	ne cause of death?
Ö	shou	lete				24a.	Was an	24b. Were auto	psy findings available
Re	ate has page 2	Completed					autopsy performed?	prior to co death?	mpletion of cause of
a t	certificate rector, pag		25. Was case referred to medical		ae Di	1 ☐ `		1 🗆 Yes	2 No
Vital		o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		Nursing Home 5		Other (Specif	iz)
o a		 	27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at		ribe how injury		Y /
ס	th. After this funeral	tlor	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	/ Work? M 1 ☐ Yes 2	2 □No			
Division	after death. Director: After	Certification;	3 Suicide 6 Could not be	289. Place of injury - At nome, farm,	street, factory, office			Number or Rura	il Route Number,
	after Dire	erti	4 Homicide	building, etc. (Specify)		City	or Town, State)		
	in the nospities of Attentuing within 24 hours after death. To the Funeral Director: After bompletely filled in by the fune	edical C	29a. Certifier Check only one) Certifying Phr	ysician: To the best of my knowledge, de ilner: On the basis of examination and/or and manner stated.	ath occurred at the time, date investigation, in my opinion, (and place, and due to death occurred at the	o the cause(s) a time, date and p	nd manner as s place, and due to	tated. the cause(s)
	ithin ;	Mec	29b. Signature and title of certifier	and manner states.	29c. License numbe	eer	29d. Date	signed (Month,	Day, Year)
ŀ	3 + 8		I Jeanine W	eins mo	D528	30	June	10.700	5
د،	-0						-	10,200	
	U		30. Name and address of person who	completed cause of death (Item 23a) (Typ	ocal #300	Anna	SANG	2 716	101
	% C	ate	31. Date filed (Month, Day, Year)	1 900 Best gutt 10	1	Timogram	- PULL		
10	ى Regist		IIIN 1 3 201		and D				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		artment of F			jiene leg. No.	05	9590
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) ELEANOR 4a. Facility Name (If not institution, give s	street and number)	201	.0	T Location of Deat		0 9/	Year 2005 Junty of Death	3. Time of Death 4/30 A M
	Funeral Director		Social Security Number 6. September 6.	Linn HOSP (1. Age (In yrs. 1. Age (In yrs. 1. 8)	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	, Year)	Coun	ace (State or Foreign ry) yland
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Healtht and Mental Hygiene. I file filen 271 is marked other tran "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner matrice is utilized at	Funerai Director	10e. Street and Number 9500 Buckhorn F	ore Co. Road 12. Was Decedent Ever in U.S. Armed Forces?		ville 10f. Zip Code	21234 dispanic Origin? (San, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Uni	n of What Counted Sta	tes an Indian,
0500-6121	within 72 hours after death within 72 hours after death wind. Ithen "natural", or Hems 23a in Medical Examinst naust a	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	1 Yes, 2 X No If Yes, Give Year or Dates: cation p completed) College (1-4or 5+)	16a. Deceo	l Yes 2 X No lent's Usual Occup kind of work done DO NOT use retired	Specify: pation during most of wo		Sp 16b. Kind		hite ustry
ylalıd 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be Co	12 yrs. 17. Father's Name (First, Middle, Last) Alexander B. 1 19a. Informant's Name/Relationship (Ty	Finn	10h Mailie		Estel	me (First, Middle, 1) le Mary ural Route Number	Maiden Sui Ree	mame) Se	
, Ma			Mr. Gregory H. Ler	nt / Son	9500	Buckhor	n Road	Baltimor	e, Ma	ryland	21234
	Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Commation 3 F 4 Donation 5 Other (Specify)	Hil	1top S		orp.June	14, 200		wson, M	
Dall	Departit Departit Imports any inju		21. Signature of Funeral Service Licens	* Michael E. Cana	pp 22	. Name and Addre	J. Ruck		5305 Balti	Harford more, M	Road D 21214
	cate be executed / Medical Medical Shaminer transit the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	pence of):						Approximate Interval Battween Onset and Death
.O. DOX	v requires that the death certifics been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[Ectopic pregnancy Other (specify)	у		23d	I. Date of delive Month	y Day Year
necolus, r	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Completed by Pl	Part II. Other significant conditions con		ilting in the u		ven in Part I.	1 Ye	es 2 N	4b. Were autoprior to condeath?	e cause of death? ably 4 Unknown sy findings available abletion of cause of
vision or vital	ft en	To Be	25. Was case referred to medical examiner? 27. Manner of Death 28. Manuer of Death 29. Matural 5 Pending 2 Accident investigation	lospital: Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur	er: 4 Nursing I	ath (Check only or Home 5 Reside 28d. Describe he	ence 6	Other (Specify	
DIVIS	ital or Atters are after decral Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	·) 			28f. Location (S. City or Town	n, State)		
	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deatl ion and/or in	vestigation, in my o	opinion, death occ se number	urred at the time, d	late and pla	ace, and due to	the cause(s) Day, Year)
	Sta		31. Date filed (Month, Day, Year)	32. Registrar a Signal	100	Print) COCH		n Bio,	BACI	I MOLE,	MD-21239
	Registr	rar .	, IIIN I	3 200 France	- 19.	CORNEL					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 Day 8:20 A M **Physician** William T. Ledley 1 come D /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Arunde 1017N DITE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 13, 2 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1⊠M 2□F 214-20-0236 78 North Carolina Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Anne Arundel Pasadena Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Old Magothy Bridge Road 21122 USA death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married ŏ White 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Maryland 21215-003 "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Carpenter Self h and Mental Hygier other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be fi Be William T. Ledley Hazel F. Lance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is neny injury or other traun Wanita Lee Ledley / Wife 205 Old Magothy Bridge Road, Pasadena, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/13/2005 Bayview Crematory Baltimore, Maryland 4 □ Qonation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. ignature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** my coward disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0 63 mc Sequenticity list for offices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 3 s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 🗌 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Pate of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records. or Attanding Physician: after death. filled in by within 24 hours a
To the Funeral C To the Hospital

Certification: To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation in my applications death occurred at the time. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print) muka DY Hospitz 30 31. Date filed (Month, Day, Year) 32. Registrar's Signature DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State of	Marylan	•	artment <i>rtificate</i>			ind M	ental F	lygie _{Reg.}	2011	5	19592
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	show		10a. State 10b. County		10c. City	y, Town or Lo	cation								10d. Inside City Limits 1 ☐ Yes 21 No
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Division of Vital	or Attanding after death. Director: After d in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At h	ome, farm, st	reet, factory	, office			28f. Locati City of	on (Stree	et and Numbe State)	er or Ru	ral Route Number,
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-	0		30. Name and address of person w	M.D., 7	601 09	BLER I	ORIVE		WSON	, M	ARYL	AMD	21204	4	
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Physician						061	uncate or t	Jeani	Mental H		4000	1959
/Medical	1	Decedent's Name (First, M. Ethel	iddle, Last)			Mar	ks		2. Date of E Month June	Day 8	2005	3. Time of Death
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Funeral Director	5	Social Security Number 214-56-6245	6. Sex	M 2 K F	. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		irth Pay, Year) 20–50	9. Birth Cou	place (State or Fore intry) Md.
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ı	Physici		Evelyn Landon	Magruder						Month June	Day 10	Year 2005	10:46 AM
	/Medic Examin		4a. Facility Name (If not institution		ber)		4b. City, Tox	wn, or Locatio	n of Death	June		unty of Death	10.40
			Sunrise Assiste	d Living-B	edford	Court	Silve	er Spri	ing		Mon	tgomer	У
	Funeral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under 1 Y Months D	ear If Und	ler 24 Hrs. s Min.	8. Date of Birti	Year)	9. Birth	place (State or Foreign ntry)
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	arms	ner	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U		Was Decedent	of Hispanic (Origin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ	can Indian,
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<u>a</u> r	uld be fenta rkad tic ev	ToB	Harry L. Lando	n				Ве	essie	M. Holb	ert		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural" or Itams 23e or 28e-f show any figury or other traumatic event, It e Maribal Examination and the confidence.	-	19a. Informant's Name/Relations	nip (Type, Print)	a.t	19b. Maili	ng Address (St	reet and Num	ber or Rura	il Route Numbe	r, City or To	wn, State, Zip	Code)
	and 2 salth n 27 I		Tennyson A. Town	nsley/ Off:	icer	148 J	ennifer	Road,	Anna	polis,	Mary1	and 21	401
altimore,	of He of He If Itar or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □ Removal from St		Place of Dispo	sition (Name o	of	June	ate	20c. Locati	on - City or To	own, State
<u>Ē</u>	Pag ment ant: lury c		'4 □ Donation 5 □ Other (S		Mon		corrum,		200	5 B		da, Ma	
Ball	ermit epart nport ny Inj nce.		21. Signature of Funeral Service	is attended		B ²²	Name and A	ddress of Fac	Robe	ert A. I	umphy	ey Fun	eral Home/ nsin Avenue
	00540		- Carol	10	MO13							WISCOI	istii Aveilue
П	<u>.</u>		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	ised the deat th line.	th. Do not ent	er the mode of	dying, such a	as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Frysician (Immediate Cause (Final disease or condition resulting in death)	Box	wel Ob	struct	ion						Days
B	/Medical Examiner			Due to (or	as a consec	quence of):						4	
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or	as a conseq	juence of):							
/	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,							
, C	exec in an	Exa	resulting in death) Last	Due to (or	as a conseq	juence of):							
8760,	cate be executed physician and the burial-transit	dicai		d									
9	rtifica ng ph as th		IF FEMALE.										
Вох	The law requires that the death certifics the has been signed by the attending pf bage 2 should be detached for use as the second of the second bage 2 should be detached for use as the second	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregna		Ectopic pregn	ancv			23d.	Date of delive	
o.	e des the at	sici	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of d	leath 5	Other (specify	v)				Month	Day Year
<u>с</u>	that the de led by the a detached t		Part II. Other significant condition	De contributing to don	th but not roo	ulting in the	adoshina save	in D.	. 1	22a Did tal			
ŝ	ires tha signed I be del	by	Tatti. Other significant condition	ns contributing to dea	in but not 195	auting in the u	nderlying cause	e given in Par	τι.				ably 4XTUnknown
Ö	w require been si should b	etec										3_7100	abiy 42 Onknown
ě	has has ge 2 s	Completed								24a. Was a autops perforr	v	b. Were autor prior to cor death?	osy findings available npletion of cause of
Vital Records,		e Co	OF Management and the second and the							1 ☐ Yes	2 🔯 No	1 Yes	2 🗆 No
	Attanding Physician: r death. actor: After this certifici by the funeral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	otiont 2	ER/Outpatien	2000			(Check only on			ASSISTED
ō	y Phy ar this eral d	\vdash	27. Manner of Death	28a. Date of	Injury	28b. Time of		4 □ r Injury at Work?	Nursing Hon 2	ne 5 Reside	winjury oc	Other <i>(Specif</i> y curred	LIVING
0	nding P th. r: After e funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	,	Day Year)	Injury		Work? 1 ∐ Yes 2 [- 1				
Division of		Certification:	3 Suicide 6 Could n	ned 286. Place of	Injury - At he	ome, farm, str	eet, factory, off	ice	2	8f. Location (St	reet and Nu	ımber or Rura.	Route Number,
٥	s after al Dirac	Cert	4 🗆 Holmoido	Building	, etc. (Specif	γ)				City or Towr	i, Stare)		
	tospital hours uneral		29a. Certifier 1⊠ Certifying (Check only 2 Medical I	Physician: To the be	est of my kno	wledge, death	occurred at th	e time, date a	and place, a	nd due to the ca	use(s) and	manner as st	ated.
	T 22 E S	ledical	3	xaminer: On the basi and manne	r stated.	ori and/or inv	,			ou at the time, di	are and plac	e, and due to	tne cause(s)
	To the within To that comple	Σ	29b. Signature and title of certifier	7/	1	1111	29c. Lic	ense number	7	2	9d. Date sig	ned (Month, L	Day, Year)
	ſ		P //	1/ //	0	1001)	V	7047	1	J	une 1	0, 200	5
	b		30. Name and address of person v					רנס	C	.4	- 1	1 0000	
	C.		Nakul Goyal, M. 31. Date filed (Month, Day, Year)				Drive	, 511V	er Spi	ring, Ma	ırylar	id 2090	6
	Sta Registra		JUN 1 3 2005	See 32. Reg	N A	person							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name_(First, Middle, Last) Month 340 AM Mason, **Physician** Samue /Medical 4a. Facility Name (If not institution, give street and number, 4b. Gity Town, or Location of Death 4c. County of Death Examiner Baltimore Medical TIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 7. Age (In yrs. last birthday) 6. Sex 6. Birthplace (State or Foreign **Funeral** 1**□**M 2□F Months 214-56-915. Usual Residence of Decedent Director and 2 should be filed within 72 hours after death with the Maryland fleath and Menta! Hygiene. In 27 is marked other than "natural", or Itams 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State other traumatic event, the Medical Examiner must be notified at Maryland 1 No 2 No Director 10e. Street and Number 10g. Citizen of What Countr 4608 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 Yes 2 No þ 3 Widowed 4 Doivorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sade 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 College (1-4or 5+) crade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mason, Sr. Ida Wideman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Mae Mason -mother 4420 Manorview Kd. item 27 I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p permit. Pages 1 Department of H Important: If ite any injury or ot 6/16/05 1 Deurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 50,0515 /Medical Due to (or as a consequence of). **Examiner** HIV/AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and I for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? res 2 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies P15851 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore Koberts M.D N. 10 32. Fügistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month,

Mason

			For	State of Maryland	/ Department			71111	19596
	G		Registrar 1. Decedent's Name (First, Middle, Last	0 , ,	Certificate	OI Deall	2. Date of Deat	eg. No.	3. Time of Death
	Physicia /Medic	al	Henry Luke 4a. Facility Name (If not institution, give	tarker	4b. City, T	own, or Location of De	June	4c. County of De	
	Examin	er	12 North Star	Court	PIL	lesville		Balt	more
	Funeral Director		5. Social Security Number 6. Se 216-42-5029	7. Age (In yrs. las	Yrs. If Under 1 Months	Year If Under 24 H Days Hours M		143	irthplace (State or Foreign
	/land low		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	.1			10d. Inside City Limits
	he Man 28a-1 ah otified	Director	MD Ball	tmore	tiles U			0g. Citizen of What (1 Tes 2 No
	23a or 2	ai Dir	12 North Star	- Court	TOP. ZIP	21208		USA	soundy?
' O	fter dea r items diner pu	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No	,	ent of Hispanic Origin? fy Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, Wi	nerican Indian, nite, etc.
0036	hours after death with the Maryland fural; or Items 23a or 28a-1 ahow at Expirit net : ust be mutified at	by	3 Widowed 4 Divorced	1 Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2			Specify: 16b. Kind of Busines	slack
21215-0036	y within 72 hours after death with the Marylan jiene Hean "nature", or items 23a or 28a-1 show Ite Madical Experiment with the multified at	Completed	(Specify only highest grad	College (1-4or 5+)	(Give kind of work	done during most of v	working	ING LL	La C
	Hyg Hyg ant,	Be Col	17. Father's Name (First, Middle, Fast)	1,	Securi	18. Mother's N	Name (First, Middle, I	Vajden Surname)	11)5
Maryland	Mer Mer Stick	To	James F. Har	Voe. Print) - 1	19b. Mailing Address	Street and Number or	Rural Route Number	Sunch City or Town. State	C Zip Code)
-	s 1 and 2 sho of Health and item 27 ia m other treum		Kosetta Bazem	ore Sister	4002 (ed	arkale k	ed., Bal	o, onD a	21215
more	of of		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ce of Disposition (Nameletery, crematory or off	per place)	17-105 (20c. Location - City	M://s //
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens		22. Via and	ddress of acid	eene Fure	. A . /	Ces 2427
			23a. Part 1. Boler the disease, or comp shock, or heart failure. List only	olications that caused the death.	Do not enter the mode	of dying, such as card	liac or respiratory arm	est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	· CEREBR		COLAR	ACCIDE	45	Onset and Death 2 cloup
١	Examiner		Sequentially list conditions,	b. Due to (or as a conseque	STENS!				Wyens
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	0515 O	F LIV	EC		Биша
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):				7
9	ate the	Medic	IF FEMALE:	d				-1'-	
O. Box	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as:	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic pre			23d. Date of d Month	lelivery Day Year
۵.	ires that I signed by I be deta	by	Part II. Other significant conditions of	ontributing to death but not result	ing in the underlying ca	use given in Part I.	23e. Did tol		to the cause of death?
Records,	e law requir has been si je 2 should	Completed					24a. Was a		autopsy findings available o completion of cause of
		e Com	OS Man and article			00 Bloom (5	perform 1 ☐ Yes	med? death	es 2 No
of Vital	Physician: this certific ral director,	To Be	1 195 212110		R/Outpatient 3□ DO	Other: 4 Nursing	Death (Check only on g Home 5 Reside	ence 6 □ Other (Sp	pecify)
ion	Attending P	ation:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	8b. Time of 28 Injury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
Division	I or Attendi after death. Diractor: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		e, farm, street, factory,	office	28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical C	(Check only 2 Medical Exam	ysician: To the best of my knowl liner: On the basis of examination					
	To the within 2 To the complex	Med	one) 29b. Signature and title of certifier	and manner stated.	29c.	License number		9d. Date signed (Mo	nth, Day, Year)
)	24		lauffer	completed cause of death (Item 2)) excost	43	6/9/20	9
	1		30. Name and address of verson who come is the common of t	R J. Meta	CHELL	MD.	1230 L	Druip	HICAVE
	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	harts.				-121/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Year 05 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical Examiner

Director

Completed by

Funeral Director

item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Madical Examinar must be notified at Pages 1 and 2 should be 1 ment of Health and Mental | ant: if item 27 is marked o

Maryland 21215-0036

Physician /Medical **Examiner**

and physician ar Division of Vital Records, P.O. Box 68760 be detached for use as the

njury or Examiner Physician/Medical þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica ပ

1. Decedent's Name (First, Middle, Last) 4a. Fecility Name (If not institution, give street and number) an our 1 6. Sex last birthday) 8. Date of Birth Days Min 1 MM 2 ☐ F Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baldimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 1100 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 No f Yes, Give fear or Dates: 1 Never Married 2 ☐ Married Black 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Mich 17. Father's Name (First, Middle, Las eterso 19b. Mailing Address (Street and Number or Rural Rouse Number, 19a Informant's Name/Relationship (Type, Print) Cousin 20b. Place of Dis 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐ Removal from State 21. Signatury of Funeral Service License 23a. Pert1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURG Due to (or as a consequence of): COPD SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) LUNG Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

4☐Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24a. Was an autopsy

performed? 1 ☐ Yes

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 **∑**Yes 2 □ No

25. Was case referred to medical 1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 - Homicide

1 Inpatient 28a. Date of Injury (Month, Day Year, 5 Pending investigation

Hospital:

2 ER/Outpatient

Other: 3□ DOA

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4 ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29c. License number

00061439

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SOSANYA A.O M.D pmes ox 30. Name and address of person whacompleted cause of death (Item 23a) (Type, Print)

WD 2 5311 OLD COULT RD, RANDALLSTOWN, MD SOSANYA AD

State Registrar

Certification:

Medical

31. Date filed (Month, Day, Year)

6 Could not be determined

а	Cransto	n i	Payne 1- State Registrar	State of Marylan		artment of F		, ,	giene	
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) Onega Cranston 4a. Facility Name (If not institution, give s	Payne		4b. City, Town, o	r Location of Death	2. Date of Dea Month June	Day	3. Time of Death 005 4:12 P
	Funeral Director			e 1	ast birthday) Yrs.	Temp 1 of Type	ir Under 24 Hrs. Hours Min.	8. Date of Birth	h	ce Georges Birthplace (State or Foreig Washington, D(
	he Maryland 28a-1 show ctiffed at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		ole Hi	lls				10d. Inside City Limits Y☐ Yes 2 ☐ No
036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Modical Examilmet must be notified at	by Funeral Director	10e. Street and Number 6417 Glen Oak Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Took Armed Forces? 1 (25/yes, 2 1) No yes If Yes, Give year or Dates:	ir 13. ars .	10f. Zip Code 20748 Vas Decedent of H f Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto Specify:			American Indian, White, etc. Black
21215-0036	od within 72 ho giene. er then "netur . tre Modical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. l		eation during most of wark of Manageme		16b. Kind of Busi	,
Maryland	should be filed ind Mental Hygis i marked other umatic event, II	To Be	17. Father's Name (First, Middle, Last) Joseph Fenton Pay 19a. Informant's Name/Relationship (Typ.		19b. Mailin	g Address (Street		Payne R		
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Importent; if item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, the Madical Examinational be retified at once.		Loretta D. Payne 20a Method of Disposition AB Burial 2 Cremation 3 Rev. 4 Doration 5 Other (Specify) 21. Signification of Funeral/Service License	emoval from State Che	lace of Dispo emetery, cren 1tenha	sition (Name of natory or other place m Milita:	ry 13 J	une 105 (20c. Location - Ci Cheltenha	hts, Md.20743 by or Town, State am, Maryland Home ston, DC20011
	Pnysician /Medical Examiner		23a. Part 1. Enfer the disease, or complice shock, of heart failure. List only on the shock of heart failure. List only on the shock of heart failure. List only on the shock of heart failure. List only on the shock of heart failure.		Approximate Interval Between Onset and Death					
8760,	ate be executed hysician and the burial-transIt	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						44-2-
.O. Box 68	death certifii e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	
<u>а</u>	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions con NABCTEL MONTO		ılting in the ur	iderlying cause giv	en in Part I.			ute to the cause of death?
Vital Records,	The ate h page	Be Completed	25. Was case referred to medical				26. Place of Deatl		med? dea 2 ☐ No	re autopsy findings available or to completion of cause of th? Yes 2 \sumbox No
	nysici nis cer direct	To B	examiner? 1X1 Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3□ DOA Oth			ence 6 Other	(Specify)
Division of	tsnding PI leath. tor: After ti the funera	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		k? Yes 2 □ No		ow injury occurred	
DİV	P Pige		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify lician: To the best of my know	") ——			City or Towr	n, State)	or Rural Route Number,
	To the Hospital within 24 hours of To the Funerel completely filled	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death occurr	ed at the time, d	ate and place, and	due to the cause(s)
^	4		30. Name and address of person who con		23a) (Type, I	Print)			June 6	2005
0	Sta	to	31. Date filed (Month, Day, Year)	7, the M.D. 32 Registrar's Signat	100	111 Penn	Street	Baltimo:	re, Mary	land 21201

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 3 2005

		1 - For State Registrar	State of Ma	aryland /		rtment tificate			and M		iene eg. No	005	195	99
Physic	ian	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dear Month	th Day	Year	3. Time of	Death
/Med		Hammie			Ro	binso				June	8,	2005	//00	(IM
Exami	iner	4a. Facility Name (If not institution, give	street and number)	Lospita	al	4b. City,	Town, or	Location o	f Deathy	rtu	4c. Co	unty of Death		
		5. Social Security Number 6. S	7. Ag	e (In yrs. last b	pirthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birthr	olace (State o	or Foreign
Funeral Director			M 2□F	95	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year)	Cou	ntry)	S.C.
ъ		Usual Residence of Decedent												
urylan show	_	10a. State 10b. County		10c. City, To								,	10d. Inside C	•
ne Ma 8a-f s	Director	Md. NA		В	alti								X□Yes	2 U NO
5-UUSO 72 hours after death with the Maryland natural, or Items 23a or 28a-1 show diral Examinat must be notitied at	Dir	10e. Street and Number 2045 Kennedy Ave				10f. Zip	2121	В		1	og. Citizen US	of What Cou	ntry?	
eath is 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13 V				nin? (Sne	ocity Yes or No-		Race - Americ	can Indian	
fter d	Fun	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 😿		1				, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.	
ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I□Yes 2	24 ∑ No	Specify:			Spi	ecify: B1	ack	
2-003 72 hours a natural; o	Completed	15. Decedent's Ed (Specify only highest gra		16	a. Deced	lent's Usua kind of wor	l Occupa k done d	ation furing most	of workii	ng	16b. Kind	of Business/In	dustry	
within iene.	mpi	Elementary/Secondary (0-12)	College (1-4or)			_			
e filed within al Hygiene. I other then vent, the Me		8th grade 17. Father's Name (First, Middle, Last)			Pipe	Laye	r	18 Mothe	r's Name	(First, Middle, I		tructi	on	
d be f	Be	Hammie		Robins	on,	Sr.		10. 14101110	Anna		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	name)		
INTE, INTERVICE LICENOSO Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at	5	19a. Informant's Name/Relationship (Type, Print)	19	9b. Mailin	g Address	(Street a	and Numbe	r or Rura	i Route Number	City or To	wn, State, Zip	Code)	
G, Ma 1 and 2 sl Health and tem 27 is not other traur		Stacy Robinson	Grandson	1	101	5 B.	Star	k St.	, Fr	ederick	, Md.	21	702	
of Hei		20a. Method of Disposition		20b. Place	of Dispos	The second second	ne of		THE RESERVE OF THE PARTY OF THE			on - City or To	own, State	
CALLIMOR Trinit. Pages spartment of l portant: If it y injury or o		1x Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	/)	Md.	Nat	. Mem	. Pk		6-15	5-05	Laur	el, Md		
Daltimo permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licen	see					s of Facilit	-					
		& lady	War	سف				I. Eas		1101 E		th Ave		
Physician /Medical Examiner		23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, from a data or the cause. Finer Underlying	a. A Spire	a consequence	e of):	rewr	nor	ua			331,		Approximate Interval Bette Onset and I	ween
ocriticate be executed certificate be executed adding physician and use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CONSES Due-to (or as	a consequence	e of):	ear kry	1	Fail.)15l	as	e				
death death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pre Other (spe					23d.	Date of delive Month	•	/ear
w requires that the been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting	j in the ur	nderlying ca	ause give	en in Part I.			oacco use d os 2 □ N	contribute to the		eath2 Jnknown
The lay	Completed								_	24a. Was an autops perform	n 24 y ned2 2 No	4b. Were auto prior to co death? 1 \(\sum \text{Yes} \)		available ause of
VICAL K ician: The certificate h rector, page	Be	25. Was case referred to medical examiner?	Lionnite!:				0			(Check only on				
OT V Physi Physi this c	2	1 Yes 2 No	Hospital:		-					ne 5 Reside			y)	
Ing Filling Fi	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	M	8c. Injury Work	rat ≀? Yes 2.⊟!		28d. Describe ho	iw injury oc	curred		
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At home, c. (Specify)	farm, stre				-	28f. Location (St. City or Town		umber or Rura	al Route Num	ber,
e Hospita 24 hours e Funeral etely fillec	edicai C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best niner: On the basis o and manner st	f examination a	ge, death and/or inv	occurred a restigation,	at the tim	e, date and pinion, deal	d place, a	and due to the ca ed at the time, da	ause(s) and ate and pla	I manner as s ce, and due to	tated. the cause(s)
To th within To th	₩	29b. Signature and title of certifier	0			29c	License	number		2	9d. Date si	gned (Month,	Day, Year)	
0		1 Soli	Curs	n ha	en		80	153	15		6	18/03	5	
2		30. Name and address of person who	L, M.C). %	ME	Print)	and	I Gr	ener	eal 1	Yosp	ntal	2	
S Regis	tate trar	31. Date filed (Month, Day, Year) JUN 1 3 20	05 Registr	ar's Signature	Apa	W)								

			State of Man	yland / Depa		Health a	and Me	-		ne 2005	19600
Phy	sician	Decedent's Name (First, Middle, Last)						2. Date of D Month	_	Qay - Year	3. Time of Death
	edical	Raymond P.		.e				June		2005	6:30a м
Exa	ıminer	4a. Facility Name (If not institution, give street 1228 Grafton Sho			4b. City, Town Bela		of Death			4c. County of Death	
Fund	rol	5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Yea		24 Hrs.	8. Date of B			lace (State or Foreign
Fune Direc			2□ F	75 Yrs.	Months Day		Min.	Month, D	ay Yea	1929 PA	lace (State or Foreign A
p »		Usual Residence of Decedent 10a. State 10b. County									
faryla shov	2	6		Oc. City, Town or Lo	Belair					10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
the N 28a-1	rect	10e. Street and Number			10f. Zip Code				100.0	Citizen of What Coun	
ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or liams 23a or 28a-f show	Funeral Director	1228 Grafton Sho	p Road			040			US		иул
death	ner	11. Marital Status 12.	Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of f Yes, specify Cu	f Hispanic Ori	igin? (Spec	ify Yes or N	0-	14. Race - America	
s after	, E	1 Never Married 2 Married	1X Yes 2 ☐ No If Yes, Give	1	1 ☐ Yes X XN			ican, etc.)		Specify: White, e	
Z7Z75-0036 d within 72 hours af gjene. ar than "natural", or	yd be	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education	Year or Dates:			1 1 1 1			4.01		
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be filed tal Hyging of other	Be C	17. Father's Name (First, Middle, Last)				18. Mothe				en Sumame)	
		Preston D.								Nicholas	
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N ×		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		IOP F			air ND Location - City or Tov	wn. State
0 00-	5	1 ☐ Burial 2 ★Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Bayview	natory or other p	ory	6/10	105		altimore	
Baltim permit. Pag Department Important: I	e e	21. Signature of Funeral Service Licensee/		22	. Name and Add	ress of Facility			-		
	a	1 K. Lerry	onnel	de l	300 Ma	ce Av				neralHome	
		23a. Part1. Enter the disease, or complicat shock, or heart failure. Lister one of	ions that caused the ause on each line.	death not ente	er the mode of d	ying, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between
Physici	_	Immediate Cause (Final disease or condition resulting in death)	CHRONIC	Lympi	HOCYTIC	LEUI	KEMI	A		,	Onset and Death
/Medio		Testing in deathy	Due to (or as a co	onsequence of):							
	e la	Sequentially list conditions, if any, leading to immediate cause. Enter thickerlying Cause (Disease or injury	Due to (or as a co	onsequence of):							
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P.C. BOX 08/00, that the death certificate be executed ed by the attending physician and delarhed for use as the british traceit	Physician/Med	IF FEMALE: 23c.	If yes, outcome of p	regnancy						001.0	
death cer death cer e attendir	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnan Other (specify)	псу				23d. Date of deliver Month	ry Day Year
by the capacity of the capacit	hvs	9 Unknown	9□ Unknown								
	á	Fait ii. Other significant conditions confine		ot resulting in the ur	nderlying cause g	given in Part I.		23e. Did		use contribute to the	a cause of death?
ecords law requires as been sign	ted	ATRIAL FIBRI	LATION					10	Yes 2	2 No 3 ☐ Proba	ably 4 □Unknown
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VICAL REC	. 0							perfe 1 Tes	ormed? 2 X N	death?	2 🗆 No
on or vical ding Physician: 1 h. After this certificat	Be	25. Was case referred to medical examiner?	oital:		0			Check only			
	- To	165 2010	1 ∐ Inpatient 28a. Date of Injury	2 ER/Outpatien	28c. Inju	other: 4 🗆 Nur				6 Other (Specify)	
Attanding r death. Sector: After by the fune	atlor	Natural 5 Pending investigation	(Month, Day Ye	ar) Injury	W	ork? □Yes 2□N					
l or Attanding after death. Director: After the tune	Certification:	3 □ Suicide 6 □ Could not be □	28e. Place of Injury - building, etc. (S	At home, farm, stre	et, factory, office	е	28	f. Location (Street a	and Number or Rural	Route Number,
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DIVISIO Do the Hospital or Attandi Within 24 hours after death To the Funaral Director. Completely filled in by the fi	edical	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:	an: To the best of m	y knowledge, death	occurred at the	time, date and	d place, and	d due to the	cause(s	s) and manner as sta	ited.
thin 2	Med	29b. Signature and title of certifier	and manner stated.			nse number				ate signed (Month, D	
F .≱ F 8		De Aures MD	HEMICA	XIST ONCOLD			5			/10/2005	
1 - //	X	30. Name and address of person who comp	lated saves of death	/h 00-) (T 1	2.:-0						
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month Year **Physician** Kandal ponard 0 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) An . 11, 1926 Maryland Hospital 6. Bex ente Carroll If Under 1 Year Funeral 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days XXM 2DF Months 79 Yrs Director 219-10-8842 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic evant, the Medical Examiner must be notified at Be Completed by Funeral Director 1 ☐ Yes XXNo MD Baltimore Reisterstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Cantata Court; Apt. 220 21136 U.S.A. Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? XXes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married XXMarried ö Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify 3 Widowed 4 Divorced natural White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Supervisor Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be itam 27 is marked o ပ Carl Vernon Randell Sarah Ethel Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Randall / Spouse 300 Cantata Ct. Apt.220; Reisterstown, MD 21136 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 6 XXBurial 2 Cremation 3 Removal from State Department of Important: If any injury of gnce. *4 □ Donation □ Other (Specify)

21. Signatur □ neral • rvice Lice St.Stanislaus Cem. 6/13/05 Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** allinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit ntra Due to (or as a consequence of) Box 68760. physician Physician/Medical the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records. 3 ☐ Probably 4 ☐ Unknown 1 Yes director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 2 40 24a. Was an autopsy performed certificate has 1 ☐ Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☐ Xo Certification: To 1 Dopatient 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1. ZNatural 2 Accident Injury 5 Pending after death, death. investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To tha Funaral D 1 🕾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2 DO05813 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner Kis 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar JUN 1 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:50 ara Rak 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. tal 1 timaze 10 JECK 5. Social Security Number 8. Date of Birth Month, Day, Year) MAR. 10, 1916 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2♥F UKRAINE 89 218-35-9982 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits items 23e or 28a-f show 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UKRAINE 1450 BEDFORD AVENUE #317 21208 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: lf Yes, Give Year or Dates: 3 ⅓ Widowed 4 □ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** CLOTHING permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Importent: If item 27 is marken any injury or or 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KLEIDMAN (UNKNOWN) ARON ZELDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 EWING DRIVE - REISTERSTOWN, MD 21136 GENNAGIY RAKHMAN / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 06/10/2005 REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., IN 8900 REISTERSTOWN ROAD - PIKESVILLE, elware 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 21208
Interval Between 1208
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 14 yeroschrotic Cardiovasculor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical thel IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1 Tes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To Director: After the 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funerel C 0

> Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 1 3 2005

30. Name and ad ress of pers in who completed cause of death (Item 23a) (Type, Print)

2 Elowa 32 Registrar's Signatur 29c. License number

29d. Date signed (Month, Day, Year)

Rundellstown , mery and

State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a&27 per me G844Centhicale deseath 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE **Physician** 2ď55 12:11P. [™] Melvin Sims /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE NA If Under 1 Year | If Under 24 Hrs. 6.Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 214-76-8663 44 Yrs Director 12-1-60 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exeminar must be notified at 1 Yes 2 □ No Directo Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 238 USA 3245 Pelham Ave death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 【XNo Specify: Specify. þ 3 Widowed 4 Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Resourceful Product Ser. Janitorial 10th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Is marked Sims, Sr. Shirley Bagley L. James 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3245 Pelham Ave., Baltimore, Md. Friend Denise Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 6-13-05 Baltimore, Md. Greenmount Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East 23a Part1. Enter the disease, or compli-shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** <u>Hypertensive Atherosclerotic Cardiovascular Disease</u> disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2□ No 24a. Was an cate has autopsy performed? **Y**es 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 2 1 Inpatient 2 XER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 OCME JUNE 7, 2005 completed cause of death (Item 3a) (Type, Print) Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

			For State Registrar		State of	f Maryland	•	artment rtificate			nd M	ental Hy	giene Røg. No.	005	19604	
	Disconini		1. Decedent's Name (Fi	irst, Middle, Las	it)							2. Date of De Month	aath Day	Year	3. Time of Death	
•	Physici /Medio				Snyde			-				6	8	200		
	Examin	er	4a. Facility Name (If not	-		nber)	T 1	0		Location o	f Death			County of Dea		
			FRANKLIN	50 U6.S		7. Age In yrs. I	A ast birthday)	If Under 1	Sec	AA/e If Under 2	A Hrs	9. Data of Riv	1 L	BAITIN	10 RE thplace (State or Foreign	
	Funeral Director		5. Social Security Numb 219-68-132		M 2⊠F		9 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Di Sept	Year)	955 Ma	aryland	
			Usual Residence of Dec									осре			aryrand	
	yland how			b. County		10c. City	, Town or Lo								10d. Inside City Limits	
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	or 28	Jire	10e. Street and Number					10f. Zip					_	zen of What C	ountry?	
	23e vi	Funeral Director	7221 Sh:	ip Way					222				USA			
	tems	nue	11. Marital Status		Armed Fo		S. 13.	Was Decede If Yes, speci	ent of His by Cubar	spanic Orig n, Mexican	jin? (Spe , Puerto I	cify Yes or No Rican, etc.)	0-	 Race - Ame Black, Whi 		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giran Year or D			·e		1 ☐ Yes 2	⊠ No	Specify:				Specify: White		
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-1 show item Maryles Evertine mail be Indiffied at	edt		15. Decedent's Education				16a. Decedent's Usual Occupation						nd of Business		
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lar	shoutd be nd Mental marked o	ToE	Leroy	Smith						Mar	y W	hitne	У			
ar	2 should be filed and Mental Hygle Is marked other aumatic evant, I		19a. Informant's Name	/Relationship (Type, Print)		19b. Mailir	ng Address	Street a	nd Numbe	r or Rura	l Route Numb	эөr, City o	r Town, State,	Zip Code)	
	1 and 2 Health tam 27		Clara He		/daugh					easa				Burni		
nore			20a. Method of Disposit 1 XBurial 2 □ C 1 Donation 5 □	remation 3		State C6	lace of Dispo emetery, crei dar H	matory or oth	e of ner place	9)		13/05		cation - City or ltimor		
Baltimore,	permit. Pages Department of Importent: If i any injury or one		21. Signature of Funera			00	22	2. Name and	Addres	s of Facility	Cor	nelly	Fun	eralHc	meofEssex	
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			23a. Part1. Enter the d shock, or heart fa	ilure. List mly	plications that c one cause on e	aused the death ach line.	De not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition	al /	a Phe	LMONI	A								0.000 0.00	
			resulting in death) Due to (or as a consequence of):													
		<u>.</u>	Sequentially list conditions, b. METASTATIC BREAST CANCER Out to (or as a consequence of):													
	ted	ng.	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):													
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	death e atte	icia	250: Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown								Month Day Year					
P.0	iras that the death cer signed by the attendir d be detached for use	hys	9 Unknown		9 Unkn	own								And the second of the second		
	as tha gned	by F	Fairth, other significant conditions contributing to about our for resulting in the underlying cause given in Fairth.							23e. Did tobacco use contribute to the cause of death?						
ğ	w require been sig should b	ed	COPD								1)2	1 Yes 2 No 3 Probably 4 Unknown				
Records,	law re as be 2 sh	Completed										24a. Was		24b. Were a	utopsy findings available completion of cause of	
Ä	The ate har page	mo.											ormed? 2 No	death?		
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of V	hysic his ce I dire	卢	1 ☐ Yes 2X No				ER/Outpatier			4 LI NU				6 □Other (Spe	ecify)	
П	ing Phys	on:	27. Manner of Death	5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		lc. Injury Work			28d. Describe	how injur	y occurred		
Division	Attanding or death, ector: After by the fune	catl	2 Accident	Accident investigation Suicide 6 Could not be 28e. Place of Injury			M 1 ☐ Yes 2 (ury - At home, farm, street, factory, office c. (Specify)					004 (-			
Ξ	or At fter d jirect in by	ıţ	4 ☐ Homicide								,		(Street an own, State		lural Route Number,	
	urs a	2	00 - O-4/6 XC	Constitution Di	- Internal Total	h t - f l		h	occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification:	29a. Certifier (Check only one)	Medical Exa	niner: On the b	asis of examination states as a state of examination of examination of examination of the state	tion and/or in	n occurred a vestigation,	in my op	oinion, dea	d place, a	ed at the time	, date and	and manner a d place, and du	s stated. e to the cause(s)	
	Fo the	Me	29b. Signature and Rice	of certifier				29c.	License	number			29d. Dat	te signed (Mon	th, Day, Year)	
		7	+ CMV	181	M			0	003	562	96		6/8	12005		
	011	П	30. Name an address	of person who	completed caus	se of death (Item	23a) (Type,	Print)				.0 17		11	1	
	V		DRJASON	BIRNE	Aum	1000 FR	ANKI	N Sq	44	QE D	R.	BALLI	mor	E /401	21237	
I	Sta Regist		31. Date filed (Month, I	JUN 1	32. F	egistrars Signa	lure	V								
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CLARA SuydeR

Amend Item 23a perState of Maryland / Department of Health and Mental Hygiene Dr., C844,06/13/05dbb Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year **Physician** nea (0:00 nola atherine Ma /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street-and number) Examiner roszville DALTIMORE 5. Social Security Number anor If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country)
A Common 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Year) Days Months 1□M 20 F -09.256 212-09-25(o Usual Residence of Decedent Yrs. Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE Funeral Director DALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 23a or 36 212 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status filed within 72 hours efter 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Completed by White 3 Widowed 4 □ Divorced Year or Dates: "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) n end Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) tari 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peges 1 end 2 should be f nent of Health end Mental f int: If Itam 27 is merked of Kin. M. Ingram ear roster ella 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of MD alask tarm Da Judy Wagyles Date 20a. Method of Disposition cemetery, crematory or other place, Department of Important: If it any injury or c 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Evens Funcial Chard-Bellin 5-2605 Forest Hill MN 22. Name and Aldress of Facility BALTIMORE, MD 21234. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee VULLERA GHAPEL, 880 HARFORD OF allows that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appropriate on each line. Surbed Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complica shock, or heart failure. List only one Physician Immediate Cause (Final disease or condition resulting in death) Deelme /Medical Examiner Due to (or as a consequence of): Aspiration Pneumonia edical Certification: To Be Completed by Physician/Medical Examine Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diceane John Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Lowsin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? certificete hes 1 Vas 3 11 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No this Director: After this d in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours e To the Funeral I 1 ** rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26/05 D31464 MD 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 821 N. Enlan 87 Smite 308 Ballmore MD 21201 SHOAIB A. HASHMI Mn 32. Registrar's Signature State Registrar

212-32-0381

Margaret Sedlak

			Please Type or Print in Black In State of Maryland / Dep	idelible Ink. Ensure All Copie artment of Health and Mental H	
		-	_ FOF	rtificate of Death	Reg. No. 005 19606
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last) Margaret Georgette Sedlak	2. Date of I Month 05	29 2005 15:17 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	, Funeral		FLNin Sula Fegianal Medical Lenter 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of E Months Days Hours Min. (Month, I	Birth 9. Birthplace (State or Foreign Country)
	Director		212-32-0381 1 M 2 VF 78 Yrs. Usual Residence of Decedent	April	28,1927 Mary Tand
	ryland how		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	he Ma	ector	MD Worcester Ocean C	ity 101. Zip Code	1 Yes 2 No
	3a or 3	Funeral Director	11 142nd Street	21842	U.S.A.
	r deatl	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
36	filed within 72 hours after death with the Maryland Hygiene. thar then "natural", or flams 23a or 28a-f show int. It c Madical Examination neillied a	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: White
Maryland 21215-0036	72 hou 'nature	Completed	(Specify only highest and e completed) (Giv.	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
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nd 2	e filed al Hygi I othar vant. I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
Vai	ould b I Menti narkad	To	Wilbur Berg	Wilma Ullr	
Ma	nd 2 st lith and 27 is n r traun		, , , ,	42nd Street Ocean City,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itams 23a or 28a-f show any injury or other traumatic event. Ite Modical Examination is notified at once.		20a Method of Disposition 20b, Place of Disp	position (Name of Date ematory or other place)	20c. Location - City or Town, State
ţi	t. Pag rtment rtant: I		`4 ☐ Donation 5 ☐ Other (Specify) Dulaney	Valley Mem. 6/3/05	Timonium, Maryland
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licensee Heather Cain	^{22. Name and Address of Facility} Leonard 5305 Harford Road Baltin	J. Ruck, Inc. more Maryland 21214
	\$		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		
Ы	Physician		Immediate Cause (Final disease or condition a. A cute renadersulting in death)	tadure	2 days
	/Medical Examiner		Due to (or as a consequence or):		2 day
	P #	iner	Sequentially list conditions, if any, leading to immediate Due to or as a consequence of):	, , , ,	
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (o s a consequence of):	heart failure	Years
760	te be e ysician ie buriż	70	d		
Box 68	Attending Physician: The law requires that the death certificate rideath. sctor: After this certificate has been signed by the attending phy; by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE:		
	eath cert attendin for use	clan/	in the past 12 mooths? 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
P.O.	es that the de igned by the be detached	hysl	9 □ Unknown		
	ires tha signed	þ	Part II. Other significant conditions contributing to death but not resulting in the	and onlying datas great in the art is	d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
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He	T e fav ate has page 2	Comp		au pe 1 🗆 Yes	prior to completion of cause of death? s 2 No 1 Yes 2 No
Vital Records,	tending Physician: T e Jeath. tor: After this certificate he the funeral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	
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Division	or Att after d Diract in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
	Hospital 4 hours Funaral	dical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de: 2 Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to t investigation, in my opinion, death occurred at the tim	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1		1 /Cult Holman	259931	6/3/05-
	10"		30. Name and address of person who completed cause of death (Item 23a) (Typ Brest HOPFMAN M.O. 108 E CAN	e, Print) (DI) ST. SALISBUY MC	5
		ate	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Typ Brey Hoffman M.O. 10b E Off 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	
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		State of Maryland / Der 1- State Amend Item 1&Unpend Item 23a, 27 Registrar	,28a-1 per me G844 Prtificate of Death	F 6-21-05	tas No.2005	10007				
Physi	cian	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death					
/Med		CARL WILLIAM SURLAND, SR.	June 3,	2005	0856 A ^M					
Exam	iner	4a. Facility Name (If not institution, give street and number)	ו	4c. County of Death BALTIMORE CITY						
		Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	8. Date of Birth							
Funera Directo	_	215-64-4562 Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	NOV. 15,	ear) 1954 MARY	ace (State or Foreign CAND				
land wo		10a. State 10b. County 10c. City, Town or	Location		10	d. Inside City Limits				
Many If sh	tor	MARYLAND ANNE ARUNDEL PASADENA				1 ☐ Yes 2X No				
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th wi		4013 MOUNTAIN RD.	21122	Ul	NITED STATE:	S				
r des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	l. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e					
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(1215-UU36 within 72 hours after death with the Maryland ene. then "natural", or litema 23a or 28a-f show the Medical Examination must be notified at	edt	15. Decedent's Education 16a, Dec	edent's Usual Occupation	16	b. Kind of Business/Indu					
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VIA ould Men Men Men Men Men Men Men Men Men Men	2	CARL E. SURLAND		TH KELLY						
Mar 12 sh 12 sh h and 7 ia m Traum	1		iling Address (Street and Number or Ru MELVIN AVE., GRASO							
		20a. Method of Disposition 20b. Place of Disp	position (Name of	_	c. Location - City or Tow					
Pages nent of I		1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, cr	ematory or other place) MEL METH. CEM. 200	E 6.	ASADENA, MAI					
Baltimore, Dermit. Pages 1 a Depertment of Hea mportant: If itam any injury or othe	oi l	A }	22. Name and Address of Facility	05 17	IDADENA, PIA	KIDAND				
Depermination of the contract			KIRKLEY-RUDDICK FUR 421 CRAIN HWY., S.	NERAL HOME	E. P.A.	21061				
Physician /Medica Examine sicien and physician and physici	1	Immediate Cause (Final disease or condition resulting in death) Methadone Intoxication; Narcotic and Cocaine Use Due to (or as a consequence of): b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
. BOX 68.	Physician/Medical I		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	/ Day Year				
requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	cause of death?				
Ke The lay te has	e Completed	25. Was case referred to medical	OR Please of Day	24a. Was an autopsy performed 1 Yes 2	24b. Were autops prior to comp	sy findings available pletion of cause of				
ysicia ysicia s cerr direct	0.0	examiner?			e 6 DOther (Specify)					
VISION OF VITAL Attending Physician: r death. actor: After this certifics by the funeral director, I	ä	The state of the s								
	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 M Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify) Found in hotel received the suit of the	oom !	City or Town, S Baltimore,		aski Hwy				
To the Hospital or within 24 hours aff To the Funeral Di completely filled in	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 2 ☒ Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	, and due to the caus rred at the time, date	e(s) and manner as stat and place, and due to the	ted. he cause(s)				
To the withing To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, De	ay, Year)				
	1	Mayrie The Shell un) OCME	Jur	ne 4, 2005					
		30. Name and address of person who completed cause of death (Item 23a) (Type		D 1						
		MANUSMAN A. KORFU 31. Date filed (Month, Day, Year) 32. Figistrar's Signature	111 Penn Street	Baltimore	, Maryland	21201				
S Regis	tate trar	31. Date filed (Month, Day Year) 32. Figistrar's Signature	Speck							

				1 - For State Registrar	State of M	aryland / l		rtment of I tificate of		d Mental I	Hygier Reg. N		
				Decedent's Name (First, Middle, La	st)		-			2. Date o		2005	3. Time of Death
		Physici		7	G.,,,					Month		ay Year	
		_/Medi		Anna Jean 4a. Fecility Name (If not institution, giv	Sponaugle			4b. City, Town, o	or Location of F	June		2005 lc. County of Dea	7:10 pm M
	7	Examir	ner							Jean I		· ·	
				Stella Maris Hosp 5. Social Security Number 6. S		C je (In yrs. last bii	eth da ul	Timoniu		Hrs R Data o		Baltimore	
1		Funeral			_ M 2 XF /. Ag		Yrs.	Months Days		Min. (Month	Birth Day, Yea	(r) 9. Bir	thplace (State or Foreign
10 O.R		Director		212-34-2147 Usual Residence of Decedent		67				3/1/	1938	Mar	ryland
ç		and **		10a. State 10b. County		10c. City, Tow	n or Loc	ation	-				10d. Inside City Limits
C		aho	5										1 ☐ Yes 2 🕅 No
0		8a-f	Director	Maryland Baltimor	e	Roseda	ıle						
		ith ti	Öİ	10e. Street and Number				10f. Zip Code				Citizen of What Co	ountry?
		23a		8525 Philadelphia				21237				J. S. A.	
		filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f ahow ant, the Medical Examinar must be routified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin an, Mexican, P	? (Specify Yes o	No-	14. Race - Ame Black, Whit	
\	9	afte or It		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 💢 If Yes, Give	No		☐ Yes 2X No				Specify:	0, 0.0.
N	8	ours iral',	d by	3 X Widowed 4 □ Divorced	Year or Dates:							Whi	.te
00	5-0036	72 h natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Deced	ent's Usual Occup kind of work done	pation	workina	16b.	Kind of Business	'Industry
ă	21	15	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retire	ed)		St	ate Boar	d of
, ,	. 5	gien er th	Ö	12		Sı	ıper	visor				ections	
0	land	be filed ital Hygie d other	Be (17. Father's Name (First, Middle, Last,					18. Mother's	Name (First, Mic	idle, Maide	en Surname)	
	<u> </u>		To	Frederick Spleidt					Evely	yn Mayhe	W		
1.1	Mary	d 2 should th and Men (7 la marke traumatic		19a. Informant's Name/Relationship (196	. Mailin	g Address (Street	t and Number o	r Rural Route Nu	mber, City	or Town, State, .	Zip Code)
3	S	and 2 s ealth ar n 27 la ier trau		James N. McKinney	(Son)		57 TAT	ise Aver	nia Dir	ndalk M	arvla	nd 21222)
4	o,	- + a =		20a. Method of Disposition	(3011)			sition (Name of atory or other pla				Location - City or	
,)	Baltimore,	Pages nent of I ant: If its		1X Burial 2 ☐ Cremation 3 ☐		E .			1 -	/13 ^{Date}			
7	Ė	permit. Pages Department of Important: If it any injury or o		*4 □ Donation 5 □ Other (Specif		Oak La		Cemetery		005		timore,	Maryland
b.	ä	permit. Departn Imports any inju		21. Signature of Funeral Service Licer			Br	Name and Addre	ess of Facility Ci Funer	cal Home	PA		
	_	<u></u> 0 = € 0		23a. Part1. Enter the disease, or com	Jaffra	,5%	14	07 Old E	Eastern	Avenue	Esse	x, Maryl	and 21221
				23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not ente	r the mode of dyi	ing, such as car	rdiac or respirato	y arrest,		Approximate Interval Between
	15	Pnysician	١.,	Immediate Cause (Final disease or condition			1	HEART	1n.				Onset and Death
		/Medical		resulting in death)		a consequence		15/1/21	LUMA	55			
		Examiner			Dae 10 (01 as	a consequence	Oij.						
			i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):						
3		ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			,						
1		and and I-trar	xan	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of)-						
	00	oe e) cian cian			240 (0) (0)	a concoquonos	J.,.						
	68760,	tificate be executed ig physician and as the burial-transit	ledical		_ d		-						
		ing p	Me	IF FEMALE:									
111	ŏ	eath cert attendin for use	Jue	23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 □	Ectopic pregnanc	:v			23d. Date of de	*
الم.	B	dea le at	Physician/M	in the past 12 months? 1 ☐ Yes 2 11 No	4☐Pregnant a 9☐Unknown			Other (specify) _				Month	Day Year
B	P.0	that the de led by the a detached	hys	9 □ Unknown	9□ Onknown								
PONAU		The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting i	n the un	derlying cause gr	ven in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
0	sp.	uires n sign ild be								1	☐ Yes	2 □ No 3 □ Pr	obabiy 4 🛣 Unknown
2	Records,	w require been sig should b	ompieted						-	24a. V	for on	24b More s	stanou findings available
0	3e	e lav has je 2	m D							a	utopsy erformed?	prior to	topsy findings available completion of cause of
0		ysician: The is certificate hadirector, page	CO								s 2 1		2 🗆 No
VI	Vital	cian ertifi ector	Be	25. Was case referred to medical examiner?						Death (Check or	ily one)		
X	of		P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatient	3□ DOA Ott	her: 4 🗆 Nursir	ng Home 5□F	esidenc <i>e</i>	ther (Spe	city) 140281CE
		ding Ph h. After th funeral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of njury	28c. Inju		28d. Descri	be how in	ury occurred	
4	<u>ō</u>	ttendir death. ctor: Af y the fu	atic	2 Accident investigation			,,		Yes 2 □ No				
NNX	Division	or Attendated attendated biractor:	ertification:	3 ☐ Suicide 6 ☐ Could not b	28e. Place of in	ury · At home, fa	ım, stre	et, factory, office					ral Route Number,
1	ā	afte Dire	ert	4 Homeade	building, et	c. (Specify)				City or	Town, Sta	10)	
		spita ours neral filled	C	29a. Certifier 1 Certifying Pt	ysician: To the best	of my knowledge	e. death	occurred at the ti	ime, date and o	lace, and due to	he cause(s) and manner as	stated
		To the Hospital or Attending within 24 hours after death. To tha Funeral Diractor: After completely filled in by the fune	dical	(Check only 2 Medical Examone)	niner: On the basis of and manner st	t examination an	d/or inv	estigation, in my	opinion, death o	occurred at the tir	ne, date a	nd place, and due	to the cause(s)
		thin thin the imple	Me	29b. Signature and title of certifier)			29c. Licens	se number		29d. D	ate signed (Monta	n. Dav. Year)
		F 3 F 8			,				11 00	-	ł		
7		Î			· .				751	2	Ju	ine 12, 2	2005
*		0		30. Name and address of person who	completed cause of o	leath (Item 23a)	(Type, F	Print)	The Country of the	^ \)		
		Ψ		DRITARIG	MAHMO	D 23	100	Manay	Valley	KD	im	m muin	D 21093
	4.	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature			' '	/	, ,		
	363	Regist	rar	JUN 1 3 2085	Braile	J. A	1000						
	DH	MH 17 Rev 1/2	001	- 1903	1	-							

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician JUNE 8, SCHUNICK 2005 5:00 A SHELLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) B. Date of Birth Month, Day Year 1940 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 ☑ F Yrs. 213-38-6414 65 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show 1 ☐ Yes 2 No Funeral Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7940 WINTERSET AVENUE 21208 USA 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. WHITE þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ PROPRIETOR DEMONSTRATION PRODUCTS Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental LANDAY REBECCA COHEN HARRY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health al Important: If Item 27 Is any injury or other trac HOWARD SCHUNICK / HUSBAND 7940 WINTERSET AVENUE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) HEBREW FRIENDSHIP CEM 06/10/2005 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 10 (av) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Wher (Specify) HOSP1Ce 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor; filled in by the 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 2 2005 W completed cause of death (Item 23a) (Type, Print) 6601 N. CHarles Street Marles Towson, MD 21204 324 Registrar's Signature 31. Date filed (Month, Day, Year) JUN 1 3 2005 Registrar

chunich, Shellen

			For State	State of Ma	aryland /		rtment of H				Diese &	005	19	610
			Registrar 1. Decedent's Name (First, Middle, Lasi	1)		OUT	meate of	Dean		. Date of Dea	ith		3. Time o	of Death
	Physicia	an	Mary	,	Szymi	usiak			J	une 7,	2005	Aeet	2:35	5 A M
	/Medic		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location				nty of Death		
	Examin	er	Rockville Nursing				Rock	kvill	e		Mont	gomer	У	
	Funeral		Social Security Number 6. S	ax 7. Age	(In yrs. last	birthday)	If Under 1 Year Months Days		r 24 Hrs. 8 Min.	. Date of Birth	Year)	9. Birth	place (State intry)	or Foreign
	Director		163-30-2907	⊒М 2 छ ्रF	91	Yrs.	Months Days	Hours	F F	eb. 8,	1914	Penn	sylvan	ia
Þ			Usual Residence of Decedent		10c. City, To		-tion		_			γ	10d. Inside (Pity Limite
arviar	d at	_	10a. State 10b. County				y Villa	œo.						s 2⊠No
M ec	Ba-1	octo	Maryland Montgome	ery	Mont	.gomer	10f. Zip Code				10g. Citizen	of Mhat Col		
with t	s or 2 ke n	Funeral Director	100.16 Diamet Book				20886				Unite			
ath y	s 23g	era	18916 Diary Road	12. Was Decedent I	Ever in II S	13 W	as Decedent of I		rigin? (Speci	fv Yes or No-	-	Race - Amer		
er de	Itam	ů,	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If	Yes, specify Cub	an, Mexica	in, Puerto Ri	can, etc.)	E	Black, White	, etc.	
S te si	, or	by F	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	Yes 2 No	Specify	<i>'</i> :		Spe	cify: Wh	ite	
5 2	atura cal E		15. Decedent's Ed	ucation	10	6a. Decede	ent's Usual Occu	pation	at of warting		16b. Kind o	Business/l	ndustry	
) L	, E W	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	ind of work done O NOT use retire	ed)	St Of WORKING			0		
, iž	giene er the	mo.	12			Sel	Lf-Emplo	4				e Owne	er	
2 4	al Hy l oth	Be (17. Father's Name (First, Middle, Last)							First, Middle,		name)		
1 1	Menta arked	To	Anton Androskovito	ch						iknejvi				
d 5	and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-1 show raumatic event, the Mudical Exactract must be notified at	0 8	19a. Informant's Name/Relationship (7		1		Address (Street							20006
and '	Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f sho other traumatic event, the Modical Exacting front ke notified at		Joan DiGioia/ Daug	ghter	ach Bloom		Diary			-		•		20886
ַב ב	of He		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Removal from State			ition (Name of atory or other pla		June		Nanty		own, State	
	ent:		`4 ☐ Donation 5 ☐ Other (Specify	′)	St. 1		s Cemete				Penns	,		
Dallillor	partment of Health a Importent: If item 27 is any injury or other tran		21. Signature of Funeral Service Licen	yplen MOOO	92	Ro Ro	Name and Address ckville ckville	ess of Faci Inc. Mar	lity Robe 300 W vland	rt A. 208500	Pumphi ntgome	rey Fu ery Av	neral enue	Home
т.	.*		23a. Part1. Enter the disease, or comp	olications that caused	the death. D								Approxima Interval Be	ate
		li o	shock, or heart failure. List only of Immediate Cause (Final	P	arkins	onism	1						Onset and Years	Death
	nysician /Medical		disease or condition resulting in death)	a Due to (or as	a consequen	ce of):								
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patric	nd ransil	Examine	that initiated events	c										
o,	an ar	EX	resulting in death) Last	Due to (or as	a consequen	ice of):								
sto be evenified	physician and the burial-transit	dicai		d					,					
۽َ مَ	ing pl	Med	IF FEMALE:											
. BOX	ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal de	ath 3 🗌	Ectopic pregnand	су			23d.	Date of deli Month	very Day	Year
	the a	hysician/Me	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	h 5∐	Other (specify) _							
ords, P.O	Maquiles that the death coming been signed by the attending p should be detached for use as it	a.	Part II. Other significant conditions of	ontributing to death b	ut not resultin	na in the un	deriving cause o	ven in Parl	t I.	23e. Did to	obacco use o	ontribute to	the cause of	death?
15,	signe signe	by	Takin Guran			•	, ,			101	∕es 2 🗆 Ne	3 🗆 Pro	bably 4 🗓	Unknown
cord	houlk	ompieted								24a. Was	20 20	Ih Wara au	topsy finding	e available
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VITAL	r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0:	thor		Check only o		011 (0		-
5	this al dii	<u>6</u>	1 ☐ Yes 2 🔀 No	1 ☐ Inpation		VOutpatient Bb. Time of	28c. Inju	4 X		e 5 ☐ Resid 3d. Describe h			uty)	
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S	or Attending rater death. Director: After in by the funera	lica	3 Suicide 6 Could not b	e geo Blace of In	jury - At home	e, farm, stre	eet, factory, office)	28	3f. Location (S	Street and No	ımber or Ru	ral Route Nu	mber,
DIVISION		Certification:	4 Homicide	building, et	ic. (Specify)					City or Tox	vn, Statej			
	vithin 24 hours at To the Funerel D completely filled in		29a. Certifier 1 X Certifying Ph	ysicien: To the best	of my knowle	edge, death	occurred at the	time, date a	and place, ar	nd due to the	cause(s) and	manner as	stated.	4-5
=	1 24 t 10 Fui letely	edical	(Check only 2 Medical Exer	niner: On the basis of and manner st		and/or inv	estigation, in my	opinion, de	eath occurred	at the time,	date and pla	ce, and due	to the cause	(S)
	withir To th	Me	29b. Signature and title of certifier		2			nse numbe	r		29d. Date si			
	•		· / / / t	- 1.)	la-	_	D2	20148			June 7	, 200	5	
	χ		30. Name and address of person who	completed cause of	death (Item 23	За) (Туре,	Print)							
	Υ /		Steven H. Dolin					e, Ga	ithers	burg,	Maryla	ınd 2	0879	
		ate	31. Date filed (Month, Day Year)	Regist	rar's Signatur	B	200							
	Regist	rar	2014 T 9 500	NO STATE	1 55	A								

			1 - For State Registrar	State	of Marylar		artment of H		Mental Hyg	iene)5	196	
	Q Dhuaiai		1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat Month	h Day	Year	3. Time of i	Death
	Physici /Medic		Josephine	Benn	ing		Tucker		June		005	8:25	a ^M
	Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, o	r Location of De	ath	4c. County	of Death		
			Heritage Har				Annapo				e Ar		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Day,	Year)	9. Birtho	lace (State or try)	· Foreign
	Director		220-16-8117 Usual Residence of Decedent	-72	80	115.			Feb. 1,	1925	Mary	yland	
	land DW		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation				1	0d. Inside City	y Limits
	Mary	ρ	MD Anne	Arunde1	Т	othian						1 🗌 Yes	2 X No
	the 28a	rec	10e. Street and Number			o chi chi	10f. Zip Code		1	0g. Citizen of V	What Cour	itry?	
	3a ol	Di	335 Marlboro R	oad			207	711		US	Δ		
	deat	Funeral Director	11. Marital Status	12. Was Dec Armed F	edent Ever in U	J.S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Rac	e - Americ	an Indian,	
တ္	after or ite		1 ☐ Never Married 2 🛣 Marr		2\CX No		1 □ Yes 2 XiNo	Specify:	erto racan, etc.)		k, White,	_{etc.} √hite	
21215-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f ehow dical Examination by Inditied at	d by	3 Widowed 4 Divorced	Year or I	ates:			орвону.		Specify	/: V	AIITCE	
5	"natu	Completed	15. Deceden (Specify only highes			(Give	dent's Usual Occup kind of work done	during most of w	vorking	16b. Kind of Bu	usiness/Ind	dustry	
7	within sne.	ф	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	2)		D a = 1-			
2	Hygie Hygie ther t		17. Father's Name (First, Middle,			BOOK	keeper	18 Mother's N	ame (First, Middle, M	Bank			
au	d be antal	o Be	Robert H. Benn						phine More		,0,		
Maryland	shoul nd Me mark	2	19a. Informant's Name/Relations			19b. Maili	ng Address (Street		Rural Route Number		State. Zip	Code)	
	nd 2 alth a 27 ia r trau		Shirley Tucker	(Daughte	r)				ad, Annapo				
re,	s 1 and 2 of Health a item 27 is		20a. Method of Disposition	<u> </u>	20b.	Place of Dispo	sition (Name of matory or other plac			20c. Location -			
E	Page sent c nt: if ry or		1 X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S		State		U.M Ceme		9-2005 1	Lothian	, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ia marked other then "natural", or items 23a or 28a-f ehow amy injury or other traumatic event, it is Mautical Examination at any injury or other traumatic event, it is Mautical Examination at any once.		21. Signature of Funeral Service	tis (1500	,				1 Home, P.				
Ω_	89 E 29		198 y.	-X		(i)	12 Ridge	ly Aven	ue, Annapo	olis, M	D 214	01	
			23a. Part1. Enter the disease, or shock, or heart failure. List	contolications that only one cause on	caused the dea each line.	th. Do not ent	er the mode of dyin	ng, such as card	ac or respiratory arre	est,		Approximate Interval Betw	reen
	Physician		Immediate Cause (Final disease or condition	. (0)	Te Arous	21 m /1	x acces	1 1				Onset and De	eath
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):		WA					
	Lxammer		Sequentially list conditions,	b	,								
i	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):							
	xecut and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	uence of):					-		
8760,	death certificate be executed e attending physician and id for use as the burial-transit				`								
687	tificate ng phys as the	Physician/Medical		d									
Вох	eath certifi attending I I for use as	J/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn					23d. Dat	e of delive	rv	
m	death s atte d for	icla	in the past 12 months? 1 Yes 2 No	4□Preg	oirth 2 □ Feta nant at time of o		Ectopic pregnancy Other <i>(specify)</i>	'		Mor			ear
0		hys	9 □ Unknown	9∐ Unkr	own								
s, P	requires that the een signed by th nould be detache		Part II. Other significant condition	ons contributing to c	eath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contr	ibute to th	e cause of de	ath?
rd	w require been sign should b	ed	Devlety,	Demen	ha				1 □ Ye	s 2 Dano	3 Prob	ably 4 □Ur	ıknown
Vital Record	aw s b s s	ompleted by							24a. Was ar		Vere autop	osy findings av	vailable
Ě	The ate h page	Сош							perforn	ied? d	leath?	2 30 No	236 01
ita	Phyaician: Th this certificate ral director, paç	Be (25. Was case referred to medical examiner?					26. Place of D	eath (Check only one	9)			355
of \	S 0 :E	ို	1 ☐ Yes 2 ◯No		Inpatient 2			Indising	Home 5 ☐ Reside	nce 6 □Othe	er (Specify)	
ū	ding Phy th. After thi funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pendin	9	of Injury hth, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurre	ed		
Sign	Attending r death. ector: After by the fune	icat	2 Accident investig	not he				Yes 2 □ No	and Leasting (Ct.	root out of blooms			
Division	l or Attenc after death Director: I in by the	ertification:	4 ☐ Homicide determ	ined 286. Plac build	ing, etc. (Speci	iome, raim, str ify)	eet, factory, office		28f. Location (Str City or Town	, State)	er or Hurai	Houte Numbe	97,
	pital	0	29a. Certifier 1 Certifyin	o Physician: To th	a best of my kno	nwledne deatl	n occurred at the tin	ne date and ola	ce, and due to the ca	use(s) and ma	nnor as str	atod .	
	the Hospital of thin 24 hours aft the Euneral Distribution of the Euneral Distribution of the Euneral Distribution of the Euneral Distribution of the Euneral Distribution of the Euneral Distribution of the European Control	edical	(Check only 2 Medical one)	Examiner: On the t	asis of examination	ation and/or in	vestigation, in my o	pinion, death oc	curred at the time, da	ite and place, a	and due to	the cause(s)	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of pertine	1			29c. Licens	e number	29	d. Date signed	(Month, E	Day, Year)	
)			DY1	1	MM		77 78	2958	6	17/0	5		
ĺ	2		30. Name and address of person	who completed cau		m 23a) (Type,	Print)	1		1-1-	1		
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	Registr	ar	0011 - 0	1.25	And the	1							

		For State	Plea				id / Dep	delible Inkartment of Interior	Health	and M		ygier	ne	ble.	
		Registrar 1. Decedent's Nam	e (First Middle	a fact)		_	Ce	Tuncate of	Deall	<i>'</i>	2. Date of D	Reg. N	100	05	3. Time of Death
Physici /Medi		Thomas N	lilton	Thoma							June 4	4, 2	005	Year	1935
Examir	ner	4a. Facility Name (4b. City, Town, o		of Death		4	tc. County		
		Upper Cl		Ke Me		7. Age (In yrs.		Be1		r 24 Hrs.	8. Date of B	lirth	нат	ford	place (State or Fore
Funeral Director		217-36-3	3762		2□ F	66	Yrs.	Months Days	Hours	Min.	Sept.	Dav. Yea	1938	Cou	yland
yland		10a. State	10b. County			10c. Cit	y, Town or Lo	ocation							10d. Inside City Lim
a-f st	ctor	Md.	Har	ford			Be1	Air							1 ☐ Yes 2 🔀
ith the	Olre	10e. Street and Nu	mber					10f. Zip Code				10g. 0	Citizen of V	What Cou	ntry?
ath w	ral	611 Kil	narnock						21014				U.S.	Α.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Itams 23a or 28a-f show any fourty or other traumatic event, the Medical Evarifical must be nutilized at once.	by Funeral Director	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	~~	ied	Was Deced Armed Ford 1√2 Yes If Yes, Give Year or Da	2 □ No e		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√ No			ecity Yes or N Rican, etc.)	10-		k, White,	can Indian, etc. hite
2 hou	ted	/0	15. Deceden	t's Education	on		16a. Dece	dent's Usual Occup	oation			16b.	Kind of Bu	usiness/Ir	dustry
ithin 7 19. Nan "n	Completed	Elementary/Seco	ondary (0-12)		<i>mpietea)</i> College (1-	4or 5+)	life.	kind of work done DO NOT use retire	during mo: d)	st of work	ing				
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be fill had oth even	Be	17. Father's Name									e (First, Middl		en Sumam	ie)	
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1 an Heal tem 2		20a. Method of Dis				20b. P	_	osition (Name of matory or other pla			Date	,	Location -		
ages ant of t: If i		1 ☐ Burial 2 `4 ☐ Donation			oval from S	late		matory or other pla Mem. Gdn		6/0	/2005		el Ai		
permit. P Departme Importen any injur		21. Signature of Fi				Бе		Name and Address Schimune.							
Enysician /Medical Examiner	er	shock, or hea Immediate Cause disease or condition resulting in death)	rtfailure. List (Final on	complicationly one c	Due to (o	ch line.	S pinatuent of):	610 W. M. H. Her the mode of dyin	ng, such as	s cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death
ficate be executed physician and ts the burial-transit	edical Examiner	cause. Enter Under Cause (Disease or that initiated event- resulting in death)	3	c d	Due to (o	or as a consequ	ditis								
The law requires that the death certificate bite has been signed by the attending physic page 2 should be detached for use as the bite.	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 0 9 ☐ Unknown	months? ☐ No	1	1 Live bir	ome of pregna th 2 □ Feta .nt at time of d wn	Ideath 3	Ectopic pregnancy Other (specify)	/			17	23d. Date Mor		ery Day Year
res that signed b be deta		Part II. Other signi	icant condition	ns contrib	uting to dea	ath but not res	ulting in the u	nderlying cause giv	en in Part I	l.	23e. Did	tobacco	use contr	ibute to th	ne cause of death?
quire; n sig uld bi	d be	Ulcero	itive.	_Co	Liti.	5					10	Yes :	2 □ No	3 🗌 Prob	abiy 4 Dunknov
sicien: The law requir certificate has been si irector, page 2 should	Completed by										24a. Was auto peri 1 Ves		d	eath?	psy findings availat inpletion of cause of
sicien: certifica rector, j	Be C	25. Was case reference examiner?	red to medical						26. Place	e of Death	(Check only				
Physic this ce al dire	101	1 ☐ Yes 2 ☑	No	Hosp	ital: 1 🕡 In	patient 2	ER/Outpatier	it 3□ DOA Oth	er: 4 🗆 Nu	ursing Hor	me 5 Res	idence	6 □Othe	er (Specif	1)
ding 1. After funer	Certification:	27. Manner of Deat 1 ☑Ñatural 2 ☐ Accident 3 ☐ Suicide	5 Pendin investig 6 Could r	gation		, Day Year)	28b. Time of Injury	Wor M 1 □	yat* k? Yes 2□	No	28d. Describe				l Route Number.
itel or A rs after el Dira led in by	Certi	4 Homicide	determ					eet, factory, office			City or To	iwn, Sta	te)		
To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1 ☐ Certifyin 2 ☐ Medical	g Physicia Examiner:	in: To the to On the bas and manne	sis of examina	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ad at the time.	cause(: , date ar	s) and mar nd place, a	nner as st ind due to	ated. the cause(s)
To th. within Fo the	Me	29b. Signature and	title of certifier					29c. Licens	e number			29d. D	ate signed	(Month,	Day, Year)
		▶ V	Mbh	your	kar	MD		123	502	フ		Ĺ	1810	05	
301,		30. Name and addi	Abbyo	on ka	eted cause	of death (Item	23a) (Type,	Print)			Air.		D		1014
Sta		31. Date filed (Mon	th Joan (41)	3 200	5 32.	gistrar's Signa	ture	code	/						

State Registrar DHMH 17 Rev 1/2001

Thomas, Thomas Milton #85110

Funeral Director

		anyland show	'n	10a. State 10b. County Maryland Carroll		10c. City, Town
		with the M 3a or 28a-f	i Directo	10e. Street and Number 4926 Roller Road	 1	
	036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportent: If item 27 is marked other then "neturel", or Items 23s or 28s-f show any injury or other treumstic event, If we Medical Examinar must be notified at 2008.	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	
)	5-0	72 ho netur	eted	15. Decedent's Educat (Specify only highest grade of		16a. E
	Baltimore, Maryland 21215-0036	filed within Hygiene. other then ent, I'm Me	e Comp	Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5	Fari
1	/lan	vuld be Mental arked o	To B	Unk.		
	Man	ind 2 sho alth and I 27 is me		19a. Informant's Name/Relationship (Type, Taratha L. Thomas		ghter 4
	imore	permit. Pages 1 and 2 should be filed with Department of Health and Menta Hygiene. mportent: If item 27 is marked other their any injury or other treumatic event, I. a. 2008.		20a. Method of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	noval from State	20b. Place of Ecometery, Greenmo
-	Balt	permit. Depart Import any inj		21. Signature of Juneral Service See	us	
		4.5		23a. Party. Enter the disease, or complicate shock, or heart failure. List only one	ions that caused cause on each li	I the death. Do no
		Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or a	515 a consequence of
	V	ted nsit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	peri ue to (or as	a consequence of
	8760,	cate be exec physician an the burial-tr	dical Exa	resulting in death) Last	Due to (or as	a consequence of
	al Records, P.O. Box 68760	n: The law requires that the death certificate be executed icate has been signed by the attending physician and r. page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death
	ords, P	equires that en signed b ould be deta	ted by Ph	Part II. Dther significant conditions contril	outing to death b	ut not resulting in t
	Reco	The law rute has be bage 2 sh	omple	anemia		1
	f Vita	if if	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital: 1/2 Inpatie	ent 2 ER/Outp
	Division of Vit	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical Certification:	Accident investigation	28a. Date of Inju (Month, Da	
	Divi	itel or Ati irs after d rel Direct led in by	Certifi	4 Homicide determined	28e. Place of Inj building, et	ury - At home, fam c. (Specify)
		To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	Medicai	29a. Certifier (Check only one) Certifying Physic	ian: To the best r: On the basis o and manner sta	f examination and/
		with	2	29b. Signature and title of Ceptation	dom	/
		1		30. Name and address of person who comp		leath (Item 23a) (T
		Sta	ate	31. Date filed (Month, Day, Year)	32. pgistr	ar's Signature

		faryland / Department of Health and	Mental Hygiene							
	1 - State Registrar	Certificate of Death	Reg. No. 2005							
cian dical			2. Date of Death Month Day Year May 31 2005 1738 PM							
niner	Sinai Hospital of Bo	altimore Baltimore	N/A							
al or	215-42-1075 ¹\\x\\\\ 2□F	ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min								
tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	10c. City, Town or Location Millers	10d. Inside City Limits 1 ☐ Yes 2√2 No							
erai Director	10e. Street and Number 4926 Roller Road	10f. Zip Code 21102	10g. Citizen of What Country? USA							
by Fun	Armed Forces 1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced Year or Dates	!? If Yes, specify Cuban, Mexican, Puèi] No 1 ☐ Yes 2 ☐ XNo Specify:	Specify Yes or No- to Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black							
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Farm Worker	Becton-Dickinson							
To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Sumame) Thomas							
	19a Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Fig. 9hter 4926 Roller Road	ural Route Number, City or Town, State, Zip Code) Millers, Maryland 21102							
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify)	Greenmoure cemeeer	Date 20c. Location - City or Town, State Haltimore, Marylan							
	21. Signature of Suneral Service Jerry	22. Name and Address of Facility Ch 5240 Reistersto	natman-Harris FuneralHome own Rd Baltimore,Md 21215							
i	Immediate Cause (Final disease or condition resulting in death)	ed the death. Do not enter the mode of dying, such as cardialine.	ac or respiratory arrest, Approximate Interval Between Onset and Death 2 days							
ner	Sequentially list conditions, if any, leading to immediate b. Peripheral vascular disease the to (or as a consequence of):									
edicai Examin	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or a	betes mellitus sa consequence of): Style renal dis	ease syear							
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	ie of pregnancy 2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)	23d. Date of delivery Month Day Year							
by	Part II. Differ significant conditions continuous to death	but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Zunknown							
Completed	anemia		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No							
To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpat	tient 2 EP/Outpatient 3 DOA Other: 4 Nursing	hath (Check only one) Home 5 - Residence 6 - Other (Specify)							
ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28a. Date of In (Month, D	fay' Year) Injury Work? Injury M 1 □ Yes 2 □ No Injury - At home, farm, street, factory, office	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,							
O		etc. (Specify) st of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.							
Medical		of examination and/or investigation, in my opinion, death occstated. 29c. License number	29d. Date signed (Month, Day, Year)							
	30. Name and address of person who completed cause of	death (Item 23a) (Type, Print)	May 31, 2005 ospital of Baltimore							
State	1111 1 0 000F K	Soh, MD Sinai Hotara's Signature	ospital of Baltimore							
strar	JUN 1 3 2005	un is positi								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Anita G. Ullrich June 8. 2005 8:20PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 14, 1921 9. Birthplace (State or Foreign **Funeral** Days Min. 1 ☐ M 2 ☐ F 84 Director 212-16-3084 Yrs MaryTand Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location or than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits MD N/A Baltimore Be Completed by Funeral Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5939 Bertram Avenue 21214 U.S.A. filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any lightly or other treumatic event. 2008. or other treumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Monath Helen Gumpman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Miller- Daughter 5939 Bertram Avenue Baltimore, Maryland 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 6/13/05 Baltimore, Maryland JUNE Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee alles 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician untus /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 11 rich, Anita Completed by 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 000 this certificate 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specific 1 ☐ Yes 2 XNo Hospital: Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Director: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö within 24 hours a

To the Funerel C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 660 IN Charles ST Baltonne up Zizay CHARLES Lory 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

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			1 - State	State of Ma	ryland / Depa Ce	artment of i <i>rtificate of</i>			2000	10015
			Registrar 1. Decedent's Name (First, Middle, Last)			Timodio oi	Doutin	2. Date of Dea	Reg. No. 4 UU	3. Time of Death
	Physici /Medic	al	Jeannette	Wetzelh	erger	4b Cib. Taura		June		1:30AM
	Examin	er	4a. Facility Name (If not institution, give s IvyHallNursingC				or Location of Deat		BALTIMO	
			5. Social Security Number 6. Sex		(In yrs. last birthday)	Mid If Under 1 Year	dle Rive	8. Date of Birth		
ŀ	Funeral Director			M 2□ ½ F	105 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May31,	1900 ma	hplace (State or Foreign buntry) RILAND
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	8a-1 sh	ctor	MD Baltin	more	Mid	dle Riv	ver			1 ☐ Yes 2 ☐ No
	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	ath w	E	1926 Wilson Po			2122			USA	
36	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🌠 Widowed 4 □ Divorced	12. Was Decedent Endemod Forces? 1 ☐ Yes 2 ☑ Note of the Property of the Pro		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S pan, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
8	hour tural	ed t	15. Decedent's Educ		16a Dece	dent's Usual Occu	nation		16b. Kind of Business	
21215-0036	⊆ = 9	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	(Give	kind of work done DO NOT use retire maker	during most of wo	rking		moosty
			8th		Home	maker	10 11 15 1 11	(F) + 44' (()	own home	
Ind	ed its b	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
3	should be and Mental s marked c umatic eve	ပို	Robert Peter	Octob	401 11 2	4.11 (2)		Kessel		
Maryland	C1 (0 - 0		19a. Informant's Name/Relationship (Ty)		b	-			r, City or Town, State, 2	
	f Health item 27 other tr		Elmer Wetzelber	rger/son	20b. Place of Dispo		drick R	oad Bal	timore Mi 20c. Location - City or	
ğ	ges tof		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crei	natory or other pla odCemete		11/05		
tim	nit. Pagartment ortant: I injury o		'4 □Donation 5 □ Other (Specify)					11/05	Baltimor	е мр
Baltimore,	permit. Pa Departmen important: any injury once.		21. Signature of Funeral Service License	onn	1: 1	Name and Address Name and Address Name	AVE CO		FuneralHo re MD 212	meofEssex
r			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused to be cause on each line	he death Do not en	ter the mode of dyi	ing, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pri	Golom.	e D	ecline			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):					
М	Examiner		Sa uentially list conditions	, De	mente	9				
**	D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	ocute nd trans	Examiner	that initiated events		en	-				
760,	te be executed ysician and ie burial-transit		resulting in death) Last	6.1	con equence of):	4				
876	ate b hysic the b	Ilcai	d		rypester	-Eun				
Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o		∃Ectopic pregnanc	ÿ		23d. Date of del	ivery Day Year
o.	at the dea by the a stached fo	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death 5	Other (specify) _			World	ouy roal
S, P	es that igned t be det	by P	Part II. Dther significant conditions con	tributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	w require been si should l							1 🗆 Y	es 2 No 3 Pr	obably 4 🗗 Unknown
of Vital Records,	The law rate has be page 2 sh	Completed						24a. Was a autops	sy prior to	topsy findings available completion of cause of
<u>=</u>		ပိ						perform 1 Yes		2□No
VIII.	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		104	A CONTRACTOR OF THE PARTY OF TH	ath Check onl or	-	
of	Phys this al dii	٠ <u>۲</u>	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatien 28a. Date of Injury	t 2 ER/Outpatier	IT 3 DOA	4TNursing F		ence 6 Other (Specow injury occurred	cify)
		ion	1 ☐Natural 5 ☐ Pending	(Month, Day	Year) Zeb. Fille o	Wo	irk?]Yes 2∐No	280. Describe no	ow injury occurred	
isi	or Attendii after death. Director: A in by the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	29e Place of Injur	y - At home, farm, str			28f Location (S	treet and Number or Ru	ral Paula Number
Division	after Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	oot, ractory, onlos		City or Town	n, State)	rai i loute i variiber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir	ner: On the basis of e	examination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and Little of certifier	and manner state	ou.	29c. Licens	se number	2	9d. Date signed (Monti	n. Dav. Year)
	F3F8	/	Dellan	9	17/1)		31464		Cholz	2.5
7	. 11		20 N	malated cours of t		Deine)	(- (-11010	
	10		30. Name and address of person who co	+SHMI,	8211	v. EUT		finte 3	308 13al	more (MI)
Ŕ.	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 1	32. Registra	Signature	Sparke	,			

31. Date filed (Morth, Day, Year) 2005

Physician

/Medical

Examiner

Director

Completed by Funeral

Be 2

Examiner

Funeral

Director

death with the Maryland

	Pleas	e Type or	Print in	Black In	delible	e Ink.	Ensu	ıre A	II Copies	Are	Legib	le.	
For		State of	of Marylai					and N	Mental Hy	giene)		
1 - State Registrar				Ce	rtificat	e of L	Death		1	Reg. No	200		19515
1. Decedent's Name	. 0		,						2. Date of De Month	ath Day	Y_ Y	'ear	3. Time of Death
4a. Facility Name (I			(ams		4h City	Ta	l acation of		JUNE			05	8.48 AM
1 D T	ARUN		STITAL		4b. City,	Town, or	Location o	Death L	1.0	40.	County of	Death A D	11.15.71
5. Social Security N	lumber 6	. Sex		last birthday)	If Under		If Under	24 Hrs.	8. Date of Birt	th	Thurs	Birthpla	ace (State or Foreign
187-20-7		1 ☐ M 2 💢 F	77	Yrs.	Months	Days	Hours	Min.	Nov. 1	4,19		Count	sylvania
Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or Lo	cation							10	d. Inside City Limits
MD	Anno	Arunde1		Sever		· 1-						10	1 ☐ Yes 2 ☑ No
10e. Street and Nun		Aldidel		pever	10f. Zip					10g. Citi	zen of Wh	at Count	
97 Eastw	<i>v</i> ay						146				USA		.,,.
11. Marital Status		12. Was Dec Armed Fo	edent Ever in U	J.S. 13.	Was Dece	dent of His	panic Orio	gin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race -		
	ied 2☐ Married	I ☐ Yes If Yes, Gir	2 X No ve		1 ☐ Yes		Specify:	, Fuerto	rican, etc.)		Specify:	White, e	
3X Widowed		Year or D	ates:	1Co Down	d==4l= 1.l=	10							White
		grade completed)	4 4	16a. Deced (Give life. I	dent's Usua kind of wo DO NOT us	n occupa rk done di se retired)	uring most	of work	in g	16b. Ki	nd of Busir	ness/Indu	ıstry
Elementary/Secon	12	College (1-40r 5+)		maker					0	wn Ho	me	
17. Father's Name ((First, Middle, La	st)					18. Mothe	r's Name	e (First, Middle,	Maiden	Surname)		
George H	lusky						Vi	ola	Newport	t			
19a. Informant's Na									al Route Numbe			ate, Zip C	Code)
Cheryl E		(Daught		_		7.0	evern		ark, MD				
20a. Method of Disp 1 ☐ Burial 2X 1 ☐ Donation	Cremation 3	☐Removal from cify)	State	Place of Dispo cemetery, crem etro Cr	natory or o	ther place		2–9–2	2005		cation - Cit ltimo	•	
21. Signature of Eur	neral Service Lic	ensee							Home, P.	.A.			
23a. Part1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death) Sequentially list confirm the sequentially list confirm the sequentially list confirm the sequential light cause. Enter Under Cause (Disease or in that initiated events resulting in death) L	rivalure. Elst offi Final n nditions, rlying injury	a Due to b Due to c.	Centic (or as a consec (Scher	shoc mic b vience of):	er the mod		JUGU		or respiratory ar	rest,		1	Approximate niterval Batween Onset and Death day
	(22)												-
IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 1 ☐ 9 ☐ Unknown	months?	1 ☐ Live b	come of pregna irth 2 ☐ Feta ant at time of d own	Ideath 3	Ectopic pro Other (spe					2	3d. Date of Month	,	ay Year
Part II. Other signific									23e. Did to	bacco us	se contribu	te to the	cause of death?
BRONCHI	IOLITIS	OBLITE	RANS	CREAM	NISIN	- PA	& LMC	nia	1 🛮 🔻	es 2[]No 3[Probab	oly 4 ⊟Unknown
									24a. Was a autops perform	sy med?	prior	r to comp th?	y findings available letion of cause of
25. Was case referre	ed to medical						26. Place	of Death	1 ☐ Yes Check only or	2☑ No ne)		Yes 2	□ No
1 ☐ Yes 2 ☑	Ñо	Hospital: 1	npatient 2 🗆	ER/Outpatient	3 DO	A Other	4 □ Nur	sing Hor	ne 5 🗆 Reside	ence 6	Other (Specify)	
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	on	of Injury h, Day Year)	28b. Time of Injury	28 M	3c. Injury a Work? 1 ☐ Ye		2	28d. Describe h				
3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Place	of Injury - At he ng, etc. (Specif	ome, farm, stre	et, factory	office	-5565	2	28f. Location (Si City or Town	treet and n, State)	Number o	r Rural F	Route Number,
one)	1 Certifying P 2 Medical Exa	hysician: To the miner: On the ba and mann	isis or examina	wledge, death tion and/or inv	occurred a estigation,	at the time in my opir	, date and nion, death	place, a	and due to the cased at the time, d	ause(s) a ate and	and manne place, and	er as state due to th	ed. e cause(s)
> St	title of certifier	Jaw	e mr)	1)	Cicense r		5		1	signed (M		
30. Name and addre	ess of person who	CBS MY	e of death (Item	S Nespr	Print) Di		ite	૩ ૮૬	alen	Buil	ile, M	0 21	061

State

Sparke

22. Registrar's Signature

			1 - For State Registrar	State o	f Marylar			t of H	lealth a	and M	lental Hy		nns	19617
	Physic	an	Decedent's Name (First, Mide	die, Last)							2. Date of D	eath Day	Yea	3. Time of Death
	/Medi		Yvonne	Theres	за	Wa	dswor	th			June	8	2005	2:40 p M
	Examir	ner	4a. Facility Name (If not instituti		,		4b. City,	Town, or	Location of	of Death		4c.	County of De	ath
			Anne Arundel	+-				napo					Anne A	
п	Funeral		5. Social Security Number 234-72-5433	6. Sex 1 □ M 2 X 1 F	7. Age (In yrs. 86		If Under Months	Days	If Under	Min.	8. Date of Bi	av. Year)	. (irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	1							May 10	,191	9 Wes	st Virginia
	yland		10a. State 10b. Count	ty	10c. Ci	ty, Town or Lo	cation					-		10d. Inside City Limits
	Mar B-1 s	ctor	MD Anne	Arunde1	A	nnapo1	is							1 ☐ Yes 21 No
	or 28	Jire	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What (Country?
	23a	by Funeral Director	448 Poplar La	ane				2	1403			1	JSA	
	er deg	nue	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Was Deceder	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	o-	14. Race - Am Black, Wh	nerican Indian,
36	s afte	Ϋ́F	1 ☐ Never Married 2 ☐ Ma 3XXWidowed 4 ☐ Divorce	If Yes, Giv	2 XX\\°		1□Yes a		Specify:				Specify:	White
9	hour tural	ed b		ont's Education	ites:	160 Dagg	tanta Hava		ation.			1 400 46		
15	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-1 show ant, It e Medical Examither rotal be notified at	Completed	(Specify only high	est grade completed)		(Give	dent's Usual <i>kind</i> of worl DO NOT usi	k done d e retired:	luring most)	t of worki	ng	160. KI	nd of Busines	s/Industry
212	d with giene ir tha	E	Elementary/Secondary (0-12)	College (1	-4or 5+)		maker					Own	1 Home	
b	al Hyg	BeC	17. Father's Name (First, Middle	, Last)		-			18. Mothe	r's Name	(First, Middle	Maiden	Sumame)	-
<u>la</u> i	Menta Menta arkad	10	Charles E. Jo	ones					В	eatr	ice Wi	1cox		
Maryland 21215-0036	2 sho and is ma aumi		19a. Informant's Name/Relation			19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City o	Town, State,	Zip Code)
3,	and lealth m 27 her tr		Carol Padgett	t (Daughter		_	and the second second		ne, A		olis,	MD 21	403	
Baltimore,	ges 1 t of H ffita or ot		20a. Method of Disposition XX Burial 2 ☐ Cremation	3 □Removal from S		Place of Dispo cemetery, cren	sition (Nam natory or otl	e of her place	9)	С	ate	20¢. Lo	cation - City o	r Town, State
Ë	t. Pa tmen tant: njury		*4 □ Donation 5 □ Other (Wa	dswort						Pine	Grove	e, WV
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, If a Madical Examination usite profilied at once.		21. Signature of Funeral Service	Licensee		22	Harde	Addres:	s of Facility Fune	ral	Home,	P.A.		
			23a. Part1. Enter the disease, of	or complications that ca	used the deat		12 Ki	ldge.	<u>ly Av</u>	enue	, Anna	polis	MD 2	
6			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on ea	ich line.	11. DO 1101 0111	51 (116 111006	or dying	, such as t	cardiac o	i respiratory a	iiesi,		Approximate Interval Between Onset and Death
	Pri ysicia n /Medical		disease or condition resulting in death)	a	Jep	212								
	Examiner			Due (0 (0	or as a cons	derice or).								
	. 2	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a conseq	uence of):								
	cuted nd ransit	Examiner	cause. Enter Underlying that initiated events	1 .										
Ö,	e exe tian al urial-t	EX	resulting in death) Last	Due to (d	or as a conseq	uence of):							-	
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dicai		d										
9 ×	eath certific attending p for use as t	/Mec	IF FEMALE:	20- 4										
Вох	attender for us	ian	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	Ideath 3	Ectopic pre					2	3d. Date of de Month	elivery Day Year
o.	at the de by the a	Physician/Me	1 ☐ Yes 2 ZNo 9 ☐ Unknown	9 Unkno	int at time of di wn	eath 5∟	Other (spe	city)						
<u>ה</u>	ge t		Part II. Other significant conditi	ions contributing to dea	ath but not resi	ulting in the ur	iderlying car	use giver	n in Part I.		23e. Did to	obacco ug	e contribute t	to the cause of death?
ecords,	quires n sign uld be	d by									10	res 2,E	3□P	robably 4 Dunknown
S	sw require s been si	oiete									24a. Was	an	24b. Were a	utopsy findings available
Re	: The law cate has I page 2 s	Completed										rmad2	prior to death?	completion of cause of
		BeC	25. Was case referred to medica	al					26. Place	of Death	(Check only o	ne)	1 🗌 Ye	s 2□ No
o† <	90 KS	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2	ER/Outpatient	3 DOA	Other			ne 5 Resid		Other (Spe	ecify)
	ding Phy h. After this funeral c	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	28	c. Injury Work?	at ?	2	8d. Describe h	now injury	occurred	
<u> </u>	Attanding r death. actor: After by the fune	cati		igation			М		es 2□N					
=	in Dirt	ertification;	4 Homicide determ	nined 289 Place	of Injury - At ho g, etc. <i>(Specif</i> y	me, farm, stre	et, factory,	office		2	8f. Location (5 City or Tox	Street and vn, State)	Number or R	ural Route Number,
_	Hospital 14 hours a Funaral (tely filled	0	29a. Certifier	ng Physician: To the b	aget of my know	ulodeo do est				1				
	To tha Hospital or within 24 hours afte To the Funaral Dir completely filled in	edicai	(Check only 2 Medical one)	Examiner: On the bas	sis of examinat	tion and/or inv	estigation, in	n my opi	nion, death	piace, a occurre	d at the time,	date and p	and manner a: place, and due	s stated. e to the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of Certific	er //			29c.	License	number			29d. Date	signed (Man)	th, Day, Year)
	d		> //	The	MO		1	Dr	51	8	7	61	8/0	
			30. Name and address of person	who completed cause	of death (Item	23а) (Туре, Г	Print)	1		Ť	(\ \	1		
			Ambe	Yu		17.	nne	17	trun	de	17	ede	cal (enter.
	Stat		31. Date filed (Month, Day, Year)	2005 A	gistrar's Signat	ture	AND D							
Π,	Registra	ar i	JON T 2	2003	wer D	MA								

	1 - For State Registrar	State of Ma		artment of Health and rtificate of Death		iene _{eg. No.} 2005	19618
Physician /Medical	Decedent's Name (First, Middle,	Last) Samue	l Edward	Wilson	2. Date of Deat Month June 10		3. Time of Death 7:43 A M
Examiner	4a. Facility Name (If not institution, Greater Baltimo	ore Medical	Center	4b. City, Town, or Location of De Towson		4c. County of De Baltimo	
Funeral Director	217 30 1702	3. Sex 7. Aga 1 ☑ M 2 ☐ F	e (In yrs. last birthday) 66 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		9. B (1929	rthplace (State or Foreign country) Md
Aaryland show	Usual Residence of Decedent 10a. State 10b. County Md	N / A	10c. City, Town or Lo	cation	·		10d. Inside City Limits 1X Yes 2 □ No
with the Marylar as or 28s-1 show be notified at Director	10e. Street and Number 3908 Milford Aver	N/A	Balto	10f. Zip Code	10	0g. Citizen of What C	
DOPP, SCM USE (Nore, Maryland 21215-0036 1998 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. 1. If item 27 is marked other then "natural", or Iteme 23a or 28a-1 show or other treumetic event, the Maryland Examinat must be notified at To Ge Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 Marrie	12. Was Decedent Armed Forces?	10	21207 Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pur 1 □ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Arr Black, Wh	ite, etc.
15-0036 n 72 hours after dea "natural", or Iteme satical Examinet mileted by Funer	3 Widowed 4 Divorced 15. Decedent's (Specify only highest	If Yes, Give Year or Dates: Education grade completed)	16a, Dece	dent's Usual Occupation kind of work done during most of w	vorking M	Specify: 16b. Kind of Busines. IcCormick	Black Sindustry Company
d 21215-00 filed within 72 ho Hygiene. other than "naturn ent, if a Mudical et Completed	Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, L.	College (1-4or 5 N/A	+)	useman Spice Blo	i		
aryland 21. should be filed wit and Mental Hygien smarked other the urmetic event. Ins. To Be Corr	James Wilson		10h Mail	Sad	ie Grimes		
e, Ma Tand 2 sl Health an Health an	19a. Informant's Name/Relationshi Barbara Ann Will 20a. Method of Disposition			ng Address (Street and Number or 8 Milford Avenue sition (Name of	Balto,	over anyther or	
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then emportent: If item 27 is marked other then only injury or other treumetic event, Item on the process.	W Burial 2 Cremation 3 4 Denation 5 Other (Spa	ecify)	King Me	morial Park 6-1 . Name and Address of Facility		Randallsto H West	own, Md
Physician /Medical	23a. Part1. Inter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Mult	iple org				Approximate Interval Between Onset and Death
Examiner	Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as:	a consequence of): OCCLYS a consequence of): CCLS a consequence of):	live Disease Crisis			
P.O. Box 6. nat the death certific d by the attending pletached for use as Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
Cords, P. requires that t been signed by should be deta	Part II. Other significant condition	s contributing to death bu	ut not resulting in the u	nderlying cause given in Part I. 10nd 11 disel	123		o the cause of death? robably 4 ⊈JUnknown
Vital Record iclen: The law requir certificate has been s ector, page 2 should BE Completed					24a. Was an autopsy perform 1 🗌 Yes 2	/ prior to	utopsy findings available completion of cause of s 2 CNo
To To	25. Was case referred to medical examiner? 1	28a. Date of Injur (Month, Day	nt 2 ER/Outpatien y 28b. Time of Injury		eath (Check only one Home 5 Resider 28d. Describe hor	nce 6 Other (Spe	acify)
Division (spitel or Attending Pours after death real Director: After filled in by the funeral Control or the funeral Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of Inju			City or Town,		·
To the Hospitel within 24 hours a Louns at To the Funeral L. completely filled Medical Ce	one)	Physician: To the best of aminer: On the basis of and manner sta	examination and/or inv	occurred at the time, date and pla- estigation, in my opinion, death oc-	curred at the time, da	ite and place, and du	e to the cause(s)
To To To Con Con Con Con Con Con Con Con Con Co	29b. Signature and title of certifier MUHTUA	Evians !	110	29c. License number		Od. Date signed (Mon	7.
State Registrar	30-Name and address of person w	no completed cause of de	ath (Item 23a) (Type, I	DODSIBY DOME	Ba	to me	21230

			1 - For State of Maryland / De Registrar	epartment Certificate				ental H	ygien Reg. N	000	E-control of the control 0610	
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of D		ay Y	ear	3. Time of Death
	Physici /Medio		Harry F. Wright Jr.					June_		2005		11:55 p ^M
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, 1	Town, or	Location of	of Death			c. County of	Death	-
			6 Morris Way			Mills If Under	04 Usp			altimo		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 7. Age (In yrs. last bir	Months	Days	Hours	Min.	8. Date of B (Month, D 6-25-	irth ay Yea 1026	r) 9	. Birthplac Country	e (State or Foreign MD
			Usual Residence of Decedent					0-23-	1920			ни
	within 72 hours after deeth with the Maryland ene. than "natureif, or Items 23a or 28e-f ehow ha Madical Examinar musi be notified at		10a. State 10b. County 10c. City, Town of	r Location	_						10d.	Inside City Limits
	Mar 6-f	by Funeral Director	MD Baltimore Owings	Mills								1 ☐ Yes 2X No
	th the or 28)ire	10e. Street and Number	10f. Zip	Code				10g. C	itizen of Wha	t Country	?
	23a	al	2 Pegram Road	211	17					USA		
	r dee	nei	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decede	ent of Hi	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	lo-	14. Race -	American White, etc.	
36	s afte	γFι	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes 2 ☐ No	1☐ Yes 2		Specify:		, , , , , , ,		Specify:	**************************************	
Ö	hour furei	a pe	3 X Widowed 4 □ Divorced Year or Dates: WWII		10						White	
Ϋ́	in 72	Completed	(Specify only highest grade completed)	ecedent's Usua i <i>ive kind of worl</i> e. <i>DO NOT</i> use	k done a	turina most	t of worki	ng	16b.	Kind of Busin	ess/Indus	try
7	iene.	шо	Elementary/Secondary (0-12) College (1-4or 5+)	lf Empl					Cab	inet M	laker	
Maryland 21215-0036	Hyg othe	BeC	17. Father's Name (First, Middle, Last)				r's Name	(First, Middle	e, Maide	n Sumame)		
<u>a</u>	Aenta Aenta rked ric ev	To B	Harry F. Wright Sr.			Dena	Day	noff				
ary	should he		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address	(Street a	and Numbe	r or Rura	l Route Numi	ber, City	or Town, Sta	te, Zip Co	de)
Σ	and 2 belth 27 i		Jacqueline D. Whitehead Daughter 1	6 Deeps	pri	ng Co	urt 1	Reiste	rsto	wn, MD	2113	36
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturei", or Items 23a or 28e-f ehow any injury or other traumatic event, the Madical Examinar must be rediffied at once.		20a. Method of Disposition \$\sum{\text{\subset}}\$\sum{\text{\text{\text{\text{\text{Purial}}}}} 2 \sum{\text{\tin}\text{\tetx{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\text{\text{\texictex{\text{\text{\text{\tin}\	sposition (Nam	e of her place	9)	D	ate	20c. l	Location - Cit	y or Town,	State
Ĕ	Pag ment ant: i		`4 □ Donation 5 □ Other (Specify) Lakevie			- 1	6-15	-2005	Svk	esvill	e. Ma	ryland
at	aparti aporti y ini		21. Signature of Funeral Service Licensee	22. Name and			у ј			tersto		
<u> </u>	80 E 9 9			Eline F			ome F	Reister	sto			
	Fnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final Issase or condition	enter the mode	1	g, such as	cardiac o	r respiratory	arrest,		Int	proximate erval Between iset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	,							1.10	(17)
	Lammer		Sequentially list conditions, b.									
	ed slt	Examiner	if any, leading to immediate ause. Enter Undenyin Cause (Disease or injury									
	be executed siclen and burial-transit	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
8760	be e siclen buris											
687	deeth certificate be executed e attending physicien and ad for use as the burial-transit	Physician/Medical	d								14 12 12	
Вох	eeth certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							23d. Date of	delivery	
ň	deeth e atte id for	Icla	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death	3 □Ectopic pre 5 □ Other (spe					19	Month	Day	/ Year
o.	t the by th tache	hys	9 ☐ Unknown									
Š,	The iaw requires that the de te has been signed by the cage 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying ca	use give	n in Part I.		23e. Did	tobacco	use contribut	te to the ca	ause of death?
Vital Records,	equire en si ould l							1 🗆	Yes 2	2□No 3[Tobably	4 □Unknown
ဝိ	= 10 01	ple						24a. Was		24b. Wer	autopsy	findings available ation of cause of
		Completed							ormed?	deat	h?	
/Ita	Attending Physicien: Thirdeath. ector: After this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?				of Death	(Check only			0	her
6	Physi this c	၉	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			4 1901	sing Hon	ne 5□Res	idence	6 ther (S	Specify)	Iteme
Ž	ding F h. After funera	ion:	27. Manne of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injur	У	c. Injury Work			8d. Describe	how inju	iry occurred		E
S	Attendid death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	М		es 2□N		0()	· · · · · · ·	- 4 8 2 4		
Division	i or Attend after death Director: , d in by the f	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory,	office		2	City or To	wn, Stat	nd Number o. e)	r Hurai Ho	ute Number,
_	spitai cours a nerei l		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred a	t the time	o date and	t place a	nd due to the	Caucole	and manne	r ac etatos	
	24 h 24 h e Fur etely	edical	(Check only 2 Medical Examiner: On the basis of examination and/o one)	investigation, i	n my op	inion, deat	h occurre	d at the time,	date an	d place, and	due to the	cause(s)
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier	29c.	License					ate signed (M		
	O		Ill mo		1)3	2184			To	nd 13	20.	v 5
1	+11		30. Name and address of person who completed cause of death (Item 23a) (Typ	oe, Print)))	, , ,	_			0.	1	1/10
4	-1		Sincethan Kishne, MD	114	251	Mas	Cen	HV V	rihe	(415)	tston	in, MD
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3 2005	y San	The state of the s							

			1 - For State Registrar		ryland / Dep <i>Ce</i>	artment o		and M			05	196	520
	Physic	ian	Decedent's Name (First, Middle, Last) Evelyn B. Webste						2. Date of Dea Month June	Day	Year		of Death a M
	/Med Exami		4a. Facility Name (If not institution, give states 4902 Gateway Terr	street and number)		_	wn, or Location timore	of Death	ouie	4c. Coun	2005 ty of Death		
	Funeral Director		5. Social Security Number 6. Security 1218–36–7089	- 24 -	(In yrs. last birthday) 56 Yrs.	If Under 1 Y Months D	ear If Unde lays Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day Feb 18,	1939	9. Birth Cou	place (State ntry)	or Foreign
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside (City Limits
	Be-f st	ctor	Maryland Baltimor	е	Baltimo	re						1 ☐ Ye	s 2X No
	with the	Funeral Director	10e. Street and Number 4902 Gateway Terra	~~		10f. Zip Co				10g. Citizen of		*	
	death ms 23	Jera		12. Was Decedent E	ver in U.S. 13.		21227 t of Hispanic Or	rigin? (Spe	ecify Yes or No- Rican, etc.)		ed St		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumstic event, If a Medical Eventret must be notified at Anne.	d by Fui	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:)	lfYes, specify 1 □ Yes 2 🔀			Rićan, etc.)	Spec.	ack, White,		
15-(n 72 h "netu	ojete(15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual O kind of work d DO NOT use n	one during mos	st of worki	ng	16b. Kind of I	Business/In	dustry	
212	filed within Hygiene. Ither then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	naker	elii ea j			Own I	Home		
	be file ital Hy od othe event,	To Be C	17. Father's Name (First, Middle, Last)						(First, Middle.		ime)		
Maryland	should ind Men marke	To	Walter J. Kelbel 19a. Informant's Name/Relationship (Ty)	o Printl	10h Maili	Add (04			. Hitte				
Z	and 2 s salth an n 27 Is I		Joseph A. Webster						l Route Number				
Baltimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition		20b. Place of Dispo cemetery, crer	isition (Name d	of .	CE, I	Paltinor ate	20c. Location	- City or To	own, State	
<u>E</u>	Pages tment of I tent: If it	18	1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 【XOther (Specify)】	Entombment	Loudon P	ark Mau	ıs.	6/11/	05	Baltim	ore, I	Maryla	ind
Ba	permit. Departr Importe any inju		21. Signatule of Funeral Service License	In an	, 22 A	. Name and A 1∩7 1√7 i 1	ddress of Facili	ty Hu	bbard F , Balti	uneral	Home	, Inc.	,
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	ations that caused to	he death. Do not ent						матут	Approxima Interval Be	ite
8760, A	/Medical Examine the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if you have a final disease or cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	Consequence of):	LUT	ERIN)E (CANC	ER		Onset and	HR.
P.O. Box 68	death certiffi e attending (id for use as	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal death 3☐ me of death 5☐	Ectopic pregna Other (specify	/)				ate of delive	,	Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con-	ributing to death but	not resulting in the ur	nderlying cause	given in Part (m _	acco use con			
ecords,	w require been sl	Completed							1 TY6			ably 4 □I	
r	0 - 0	ошо							24a. Was ar autops perforn	y neg?	prior to con death?	psy findings npletion of c	available ause of
Vital	sicien: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?				26. Place	of Death	(Check only on		1 🗆 Yes	2 L No	
Ö	Phys this ral dii	5	1 Yes 2 No Ho	ospital: 1 Inpatient 28a. Date of Injury		3 DOA		irsing Hom	-/-	nce 6 Oth		')	
	fter	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day)	(ear) 28b. Time of Injury		njury at Work? 1 □ Yes 2 □		8d. Describe ho	w injury occur	rred		
DIVISION	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, stre (Specify)				8f. Location (Str City or Town	reet and Numb . State)	ber or Rural	l Route Num	ber,
	he Hospit in 24 hour he Funere pletely fille	edicai (29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	cien: To the best of er: On the basis of ea and manner state	xamination and/or inv	occurred at the	e time, date an ny opinion, dea	d place, a th occurre	nd due to the ca d at the time, da	use(s) and ma ite and place,	anner as sta and due to	ated. the cause(s)
	To T COURT	Σ	29b. Signature and title of certifier	MD			ense number 6354	Ĺ	l l	Od. Date signe			-
	6		30. Name and address of person who con E.W. COLEMD	STA6NE	th (Item 23a) (Type, F	CATON	JAVE	BA	LTIMOS	RE MI	0 2	122	9
E	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's									1
DHA	MH 17 Rev 1/2	- 3	JUN 1. 3 201	15 Modern	U A A	north o							
					ORIGINA	L							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** (0 /Medical

Funeral Director

Examiner

Director

Be Completed by Funeral

٩

2 should be filed within 72 hours after death with the Maryla and Mental Hygiene is and Mental Hygiene is a set its marked other than "natural", or Items 23a or 23a-f show is martic event, the Marical Evaning the mustic event, the Marical Evaning the mustic event, the Marical Evaning the must be natified as

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.

Baltimore, Maryland 21215-0036

Physician /Medical

The law requires that the death certificate be executed attending physician and ģ certificate or Attending Physician: this funeral After death. after death

P.O. Box 68760.

Division of Vital Records,

filled in by within 24 hours a

Examiner Examiner Physician/Medical ģ Completed Be Certification: To Medical To the

3. Time of Death 1627FM 195 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Baltimore AIU If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠**M 2□F 219 22 8230 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YORK HANDVER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Roan asmine USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No ASS NO ASS No ASS No ASS NO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MACHINIST Commercia 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Zepp MARGARET BROTHERS George 19a. Informant's Nam elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 JASMINE ROAD HANOVER Wineke 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CARROLL GREMATORY, INC 6/13/2005 HAMPSTEAN *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBRUN FHE Sykesville Road ELDERS bung mo 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of) Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arter Disease Bespiraton Congestive heart Collision Vehicle 25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

4☐Pregnant at time of death

1 Inpatient 2 ER/Outpatient

28b. Time of

5 Other (specify)

24a. Was an autopsy 26. Place of Death (Check only one) Other: 3 DOA

28c. Injury at Work?

1 🗌 Yes 2 2 No 1 TYes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

St. Baltimore,

performe

Injury 1727 MVC 1 ☐ Yes 2 X No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury : At home, farm, street, factory, office building, etc. (Secify) Illchester+ Ketger Kds, Ellicott City

28a. Date of Injury (Month, Day Year)

04/10/05

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie Sur 29c. License number 16559

South Greens

29d. Date signed (Month, Day, Year)

Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHOLAT MI 22

31. Date filed (Month, Day, Year)
JUN 1 3 2005 State Registrar

Natural

2 Accident
3 Suicide

4 Homicide

(Check only one)

29a. Certifie

5 Pending

investigation

6 Could not be determined

in the past 12 months? 1 ☐ Yes 2 ☐ No

32. Registrar's Signature

			1 - For State Registrar	State of M	<i>l</i> arylan		artment of H			ental H	Eug %	05	19622
			Decedent's Name (First, Middle, L.)	_ast)						2. Date of D	Reg. No.		3. Time of Death
	Physici		Ida May Ashfor	-d						Month	Day 30	2005	4: 15 AM
	/Medic Examir		4a. Facility Name (If not institution, g	ive street and number	or)		4b. City, Town, or	r Location		TINY		unty of Death	7 10
1			SAINT AGNE	S HEAL	THO	ARE	BALTI	MC	RE				
	Funeral		Social Security Number 6.	Sex 7.		last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of B	irth	9. Birth	place (State or Foreign
	Director		207–12–5367	1 □ M 2 □ XCF	80	Yrs.	Months Days	Hours	1	Oct.	4, 1924	Coui	PA
	pua 🛦		Usual Residence of Decedent 10a. State 10b. County		10c Cin	, Town or Lo	agtion						and the law City Live in
	sho	7	MD Baltim	ore	100. 0115	y, TOWITOLE	Catons	257111	0				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	ect	10e. Street and Number					2 1 1 1	.e		10. 011	/111	
	with	급	717 Maiden Choi	go Tano (r⊨ 10	E	10f. Zip Code	20			10g. Citizen	of What Cour	ntry?
	eath	eral	11, Marital Status	12. Was Deceder			2122		rigin? (Spe	oifu Vas or N	0- 14	USA Race - Americ	an Indian
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. ad othar than "neturel", or items 23e or 28e-f show avant, it a Madical Examinar must be notified at	by Funeral Director	1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	Armed Force	s? ₫ No		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:		Rican, etc.)		Black, White,	
9-0	72 ho	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation			16b. Kind o	of Business/In	dustry
21	C * 40	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	kind of work done o DO NOT use retired	during mos I)	st of workin	g			
	filed withi Hygiene. ethar than	9		4	,		Homemak	ær				Ho	me
P	be file tal Hy d oth avant	Be (17. Father's Name (First, Middle, Las	st)				18. Moth	er's Name	(First, Middle	e, Maiden Sun	name)	
yla	should be filed within Mental Hygiene. I marked othar than umatic avant, the Mental Hygiene.	ဥ	John Nice Ruth							e Murr			
	2 2 2 2	. 19	19a. Informant's Name/Relationship										^{Code)} 21228
	and Balth n 27	1	Robert L. Ashfo	rd/Husband			Maiden Ch	oice					
imor	to to		20a. Method of Disposition 1 Burial 2 XCremation 3 4 Donation 5 Other (Spec		te Co	etro C	sition (Name of matory or other plac cematory		May 2	005	Balti	on - City or To More,	MD
Ball	permit. Pag Department Important; I any injury o		21. Signature of Funeral Service Lic	eun.		12 14	Name and Address arranco 8 95 Gov. F	s of Facili Son: Ritch	s, P. ie Hw	A. Sev y, Sev	verna P verna P	ark Fu	neral Home D 21146
П			23a. Part. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	ed the death line.	. Do not ent	er the mode of dying	g, such as	cardiac or	respiratory	arrest,		Approximate Interval Between
F	nysician	i n	Immediate Cause (Final disease or condition	. A	DRTI	IC.	STENC	12(S				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):							io funite
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequ	uence of):						-	
	cate be executed physician and the burial-transit	Examiner	that initiated events	С.									
0,	e exe ian a urial-t	EX	resulting in death) Last	Due to (or a	is a consequ	ience of):							
68760,	cate b physic the bi	dical		d.									
		Mec	IF FEMALE:			_							
O. Box	that the death certificated by the attending point of detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetel	death 3[Ectopic pregnancy Other (specify)					Date of delive Month	ery Day Year
s, P	requires that the een signed by th nould be detache	by Pł	Part II. Other significant conditions	contributing to death	but not resu	ılting in the u	nderlying cause give	n in Part I	L	23e. Did	tobacco use c	ontribute to th	ne cause of death?
rds	equires en signe ould be		HYPONAT	REMI	4					10	Yes 2□No	3 ☐ Prob	ably 4 Unknown
of Vital Record	> 40 70	Completed	CHULOTH	HORAX						24a. Was	s an 24	b. Were auto	osy findings available
E E	9 4 6	mo	0117011	1015/17						auto perf	ormed?	death?	psy findings available inpletion of cause of
ta	certificate ector, pag	O	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes (Check only	2XINo	1 L Yes	2 No
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Division	Attanding r death. ector: After by the fune	ertification:	1 △ Natural 5 ☐ Pending 2 ☐ Accident investigati	on	ay rear	injury		res 2 🗆	No				
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ā	tal or s afte al Din ed in	Cer		bullaing,	oto. (Opecity	/				City of To	WII, SIZIE)		
-	To the Hospital of Attanswithin 24 hours after deatl To the Funeral Director; completely filled in by the	edical	29a. Certifier (Check only one) Certifying F	Physician: To the bes aminer: On the basis and manner:	of examinati	wledge, death ion and/or in-	occurred at the time restigation, in my op	e, date an pinion, de <i>a</i>	nd place, ar occurred	nd due to the	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)
	o tha within 2 To tha complet	Σ	29b. Signature and title of certifier	0 0000		7	29c. License				29d. Date sig		
)			Ghlan	2 000	M	シ	PI	86	06		MAY	30	, 2005
			30. Name and address of person who	900	CAT	NO	AVENU	E	BAL	TIMO	ORE	MD	21229
	Sta		31. Date filed (Month, Day, Year)		trar's Signat		1 0						
	'Registr		MAY 3	L 2005	and the same	No. 1							

DHMH 17 Rev 1/2001

ASHFORD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ann L. August 12:40 A.M May 24, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√2 F 81 Yrs. Director 220-12-3159 January 12, 1924 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or opper traumatic event, the Marical Exercises. 10c. City, Town or Location Rockville 10a State 10b. County 10d. Inside City Limits Maryland Montgomery 1 XYes 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9701 Medical Center Drive United States 20850 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo 3 SWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done do life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Bank Secretary 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Madeline Ziler Hugh Dent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Sharon Bowden/ Daughter 11407 Hawks Ridge Terrace Germantown, MD 20876 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 200. Place of Dispusions of other place).

Georgetown University May 24

2005 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 1 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, 21. Signature of Funeral Service License P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No signed by the 9 Unknown 9 Unknown Part II. Other-significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 1 Yes 204 1 Yes 2 or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ Other: 2 1 Inpatient 4 Hursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27 Manner of Peath 28b. Time of Certification: 28d. Describe how injury occurred Director: After 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Sigpajure title of certifier

Registrar

State

Kavi Dass 31. Date filed (Month, Day, Year)

27

2005

Division of Vital Records, P.O. Box 68760,

Sceend AVE, # YOYB Silver sping,

and address of person who completed cause of death (Item 23a) (Type, Print)

609

			1 - For State of Registrar	Maryland / De	partment ertificate				giene ()5	9624
I	Physicia		Decedent's Name (First, Middle, Last) TSAIAH BUIE ANDERSON					2. Date of Dea Month MAY	Day	Yeer 2005	3. Time of Death 2:18A M
	/Medic Examin		4a. Facility Name (If not institution, give street and num	nber)	4b. City, To	own, or Lo	cation of Dea			ty of Death	
			PRINCE GEORGES HOSPITA				VERLY			INCE GE	
	Funeral Director		5. Social Security Number NONE 6. Sex XX M 2□ F	7. Age (In yrs. last birthd Yrs	Months (Under 24 Hr Hours Mir 1		Year) 2005	Country	ce (State or Foreign y) LRLY, MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location			<u> </u>		100	d. Inside City Limits
	Maryl -1 sho	tor	MARYLAND PRINCE GEORGES	ACCOKER	EΚ						XX Yes 2 □ No
	r 28a	Directo	10e. Street and Number	Hoodin	10f. Zip C	ode		-	10g. Citizen of	f What Country	y?
	23e c		16107 LIVINGSTON ROAD			206				ED STAT	ES
	tems	Funeral	Armed Fo	dent Ever in U.S.	 Was Deceder If Yes, specify 	nt of Hispa y Cuban, I	anic Origin? (Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Ra Bi	ace - Americar ack, White, etc	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28a-f show any injury or other traumetic event, the Medical Eracili actional be recitified at once.	by F	XX Never Married 2 Married 1 Yes If Yes, Giv Year or Da	е	1□Yes XX	Ū No . 5	Specify:		Spec	ity: BLAC	:K
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	be filed water that Hygier and other the event, In	S	0 17. Father's Name (First, Middle, Last)		NONE	18	Mother's N	ame (First, Middle,		NONE	
au	ld be i ental I ked o	To Be	CRAIG ANDERSON					E HAMPTO		,	
Maryland	should and Men s marke	-	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (5			Rural Route Numbe		n, State, Zip C	ode)
	and 2 ealth a n 27 is		KERNIECE HAMPTON / MOTHE		07 LIVIN		N ROAI			20607	
Baltimore,	Pages 1 nent of He int: ff iter iry or oth		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from	State	crematory or othe	er place)	1	Date	20c. Location	n - City or Tow	n, State
i E E	rtmen rtant: njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	WASHING	TON NAT			5/28/05	SUITI	LAND, M	íD
Ba	permit. Departr Importa any inji		a. Parel 2	9	MARSHALI 4308 SUJ	L'S F	UNERAI	HOME OF		AND, INC D 20746	
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	Priysician /Medical		resulting in death)	REME PREMAT	URITY						
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8760,	death certificate be executed e attending physician and of for use as the burial-transit		Due (o)	or as a consequence or).							
687	ificate g phys as the	edlc	d								
Вох	eath certific attending p	M/us	23b. Was decedent pregnant	come of pregnancy	3 ☐Ectopic pred	nancv				ate of delivery	
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ion	Attending F r death. ector: After by the funera	atlo	2 Accident investigation	th, Day Year) Inju	M		s 2□No				
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	the Horin 24 h the Fur	edical	(Check only 2 Medical Examiner: On the b	asis of examination and/oner stated.	or investigation, in	n my opini	ion, death oc	curred at the time, o	date and place	and due to the	ne cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. I	License n	umber	2		ned (Month, Da	
			1	-		D0026	5819		MAY	26, 200)5
)			30. Name and address of person who complised caus	e of death (Item 23a) (Ty 3001 HOSF		TVF	CHEV	ERLY, MD	20785		
	Sta	ate		egistrar's Signature	_	- V L	OLLE V.		_0/05		
	Regist		MAY 3 1 2005	in to be	meli						

James Ahern 05-03 NJM

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

5-03816 ™		Amend item#23a,27,22a-f,perME,6851,1719/06-fff the Ensure State of Maryland / Department of Health and 1- State Unpend Item 23a&27 per me G844-6-fificate of Death	Mental Hygi	ene ()) 5	1962	5
Physicia	an	Decedent's Name (First, Middle, Last) JAMES THOMAS AHERN	2. Date of Death Month June	1 0000	2005	3. Time of Death	h
/Medic Examin		4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital 4b. City, Town, or Location of Dec Cumberland	_ 1	4c. County	of Death	2340	IVI
Funeral Director		5. Social Security Number 212-88-4642 Usual Residence of Decedent 6. Sex 12 M 2 F 28 Yrs. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir	n. (Month, Day,	Year) 1976	9. Birthpla Counti MARY	ace (State or Fore ry) LAND	sigr
he Maryland	ector	10a. State 10b. County 10c. City, Town or Location MD ALLEGANY CUMBERLAND 10e. Street and Number 10t Zin Code				d. Inside City Lim	
h with 1	ai Dir	106. Street and Number 107. POLK STREET, APT. 5 21502	10	g. Citizen of W		y?	
be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue If Yes, Give Year or Dates: Unknown	Specify Yes or No- rto Rican, etc.)	14. Race	- America K, White, e		
within 72 houndless.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of well- life. DO NOT use retired) LABORER	orking	6b. Kind of Bu	siness/Indu		
should be filed and Mental Hygin s marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ame (First, Middle, Ma	ROOFI aiden Sumame			
1 and 2 Health a em 27 Is		19a. Informant's Name/Relationship (Type, Print) JENELL AHERN ? WIFE 20b. Place of Disposition 19b. Mailing Address (Street and Number or F 411 GREENE STREET,	CUMBERLANI		21502	2	_
permit. Pages Department of I Importent: If Itt any injury or of		1 Burial 2000 remation 3 Removal from State CUMBERLAND CREMATORY 06/0 21. Signature of Funeral Service License CUMBERLAND CREMATORY UPCHURCH FUNERAL	7/2005	CUMBE			
/Medical Examiner We private and Privat	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	on.			Onset and Death	
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	Completed		24a. Was an autopsy performe	d? de	or to comp at 1?	y findings availab pletion of cause of	le I
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		30. Name and address of person who completed cause of death (Item 23a) (Type, Print 11 Penn Street	Baltimon	re, Mar	yland	21201	
Stat Registra		JUN 1 0 2005 31. Date filed (Month, Day, Year) JUN 1 0 2005					

Registrar DHMH 17 Rev 1/2001

		1	State of Maryland / Department of Health State of Maryland / Department of Health Per Dr., G844,06/10/05dhb Registrar	, ne	ig. No.
ı	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Michael R. Anderson	2. Date of Death	9 2005 2330 M
	Examin	er		or 24 Hrs. 8. Date of Birth	4c. County of Death 9. Birthplace (State or Foreign Country)
	Funeral Director		@ 223-11-9682 11 M 2 F 39 Yrs. Months Days Hours Usual Residence of Decedent	Min. (Month, Day, 10/22/1	
	//ary!and f ehow ed al		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ★No
	or 28a-	Director	VA Loudoun Leesburg 10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Country?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If if eath and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examplant and or other traumatic event, the Madical Examplant and or other traumatic event, the Madical Examplant and or other traumatic event, the Madical Examplant and or other traumatic event, the Madical Examplant and or other traumatic event, the Madical Examplant and or other traumatic event, the Madical Examplant and or other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event, the Madical Examplant and other traumatic event and other traumatic event and other traumatic event and other traumatic event and other traumatic event and other traumatic event and other traumatic event and other traumatic event and other traumatic event	by Funeral	18810 Granite Falls Lane 20175 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No 1 □ Ye	can, Puerto Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
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lary	2 shoul and Mi is mari	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num		
ø.	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. 2059.		Mary B. Anderson – Wife 18810 Granite Fal 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Date	20c. Location - City or Town, State
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 22. Name and Address of Fac	Colonial	Leesburg, VA Funeral Home eesburg, VA 20176
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	as cardiac or respiratory arre	Approximate Interval Between Onset and Death
	death certificate be executed e attending physician and id for use as the burial-fransit	dlcal Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):		
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Vital	Physician: Th rthis certificate ral director, pag	o Be		ace of Death (Check only on Nursing Home 5 Reside	
Division of	ding After fune	atlon; T	27. Manner of Death Statural Statural Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 1 Yes 28c. Injury at Work?	28d. Describe ho	ow injury occurred
Divis	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Number or Rural Route Number, n, State)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Check only one) Control in the date of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, of and manner stated.	death occurred at the time, d	date and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
•	lla		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		MAY 19 2005
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	Regis	tatė trar	31. Date filed (Month, Day, Year) JUN 1 0 2005		

DHMH 17 Rev 1/2001

State

Registrar

MAY 3 1 2005

IAME

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis ElderCare Severna Park 8. Date of Birth (Month, Day, Year) Jun. 30, 1917 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 XF 213-05-7309 87 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Anne Arundel Severna Park Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 650 Benfield Road 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is markad other than Elementary/Secondary (0-12) College (1-4or 5+) Beautician 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Clare Benson Florence Elliott 2 19a. Informant's Name/Relationship (Type, Print) nt of Health a 650 Benfield Road, Severna Park, MD Millicent Clare Bock/Daughter permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr 20b. Place of Disposition (Name of cemetery, crematory or other place) ^{Dat2}8, 2005 20a. Method of Disposition Metro Crematory or other p 1 ☐ Burial 2 ACremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque **Examiner** Tal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) the burial-Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical ası IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2/25No 9☐ Unknown 9 Unknown 5 Part II_ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò

1. Decedent's Name (First, Middle, Last)

Millicent J. Bock

Physician

/Medical

been signed be deta 20 Completed page 2 s has certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28b. Time of **Unk** 28c. Injury at Injury Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Certification: 5 Pending investigation 1 Natural May 13th 2005 1 Tyes 2 No tal 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) 4 \(\text{Homicide} \) 29a. Cartifier cal

State Registrar

MAY 3 1 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

k-AmbalayanaV 31. Date filed (Month, Day, Year)



MUL

amend item#28b, perME, G844, 6/13/05 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 2. Date of Death

2005 11:40a M 4c. County of Death

Anne Arundel

 Birthplace (State or Foreign Country) NY

10d. Inside City Limits

1 ☐ Yes 2 No

USA

14. Race - American Indian, Black, White, etc. White Specify

16b. Kind of Business/Industry

Beauty Shop

18. Mother's Name (First, Middle, Maiden Sumame)

May

25,

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Certificate of Death

20c. Location - City or Town, State

Baltimore, MD

Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Approximate Interval Between Onset and Death 6 Blauss

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 🗌 Yes 2)X No 3 Probably 4 Unknown

24a. Was an autopsy periormed? res 22 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City of Jown, St. e) 650 Sene L. d. Road Seve

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

2005

MD 21061 alen Burno

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician:

		Plea					artment of H				_	_
	-	For State Registrar	Ole	ALC OF IVE	ai y lai l		ertificate of i			Reg. No.	2005	5 19629
	2	Decedent's Name (First, Midd	le, Last)						2. Date of De		Yea	3. Time of Death
Physicia /Medic		Charles Gordo	n Bell	, Sr.			· · · · · · · · · · · · · · · · · · ·		MAY	(a	8 200	5 1204 M
Examin		4a. Facility Name (If not institution			Llan			Location of Death		1	County of De	ain ester
Ewarana		5. Social Security Number	6. Sex	reval	ge (In yrs. I	ast birthda	() If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. B	irthplace (State or Foreign Country)
Funeral Director		166-28-6316	1 ∑ M :	2 🗆 F	71	Yrs.	Months Days	Hours Min.	Oct. 2	4,193	3 Per	insylvania
pu .		Usual Residence of Decedent 10a. State 10b. Count	,		10c. City	, Town or	Location					10d. Inside City Limits
Maryland -f show	ror		Arunde	1	Arno	1d						1 □ Yes 21 No
7 m m m m m m m m m m m m m m m m m m m	Director	10e. Street and Number		-			10f. Zip Code			10g. Citiz	ten of What	Country?
illed within 72 hours after death with the Hygiene. Why the ham shaturel, or litems 23e or 28e and, the Modical Examinar must be notified.		1144 Greenhill					21012				USA	
Z er des	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	A	/as Decedent med Forces	? 195	s. 54 -	If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)	o- 1	Black, Wi	nerican Indian, nite, etc.
urs aft	þ	3 ☐ Widowed 4 🗓 Divorce	lf.	Yes, Give ear or Dates:	195	56	1 ☐ Yes 2 🖾 No	Specify:			Specify:	White
72 hou	Completed	15. Decede	nt's Education	n npleted)		(Gi	edent's Usual Occup ve kind of work done	during most of wor	rking	16b. Kir	nd of Busines	ss/Industry
within ne.	mpl	Elementary/Secondary (0-12)	C	ollege (1-4or	5+)		. DO NOT use retired sman	a)		Ori	ental	Rugs
filed v Hygie other i		17. Father's Name (First, Middle	, Last)					18. Mother's Nar	me (First, Middle			
should be nd Mental marked o	To Be	Thomas Gordon	Bell						ny Minor			
2 should be filed within and Mental Hygiene. Is marked other than reumetic event, It a M		19a. Informant's Name/Relation					iling Address (Street					, Zip Code)
s 1 and 2 should be filed within 72 hours after death with the Marylan in Health and Mental Hygiene. If Health and Mental Hygiene is the marked other than "naturet", or Items 23e or 28e-f show other treumetic event, It a Madical Examinar must be notified at		Eleanor W. Bel	1/Frie	nd	20b. P		Greenhil position (Name of rematory or other place		Arnold,			or Town, State
Pages nent of h		1 Burial 2 Cremation 4 Donation 5 DOther			Э			101	2005			, Maryland
그 문원 중		21 aure of Fin eral Service		COMOME	1/1		22. Name and Addre Zeller Fun					,
Dermi Depar Impor eny ir	1	sonerel	w	Sell	ur	/ 1	106 Main S	treet, E	ast New	Mark	et, M	
	-	a. P. 111. Enter the disease, hock, or heart failure. Li	or complications one ca	e on each	line.		enter the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Rhabd Due to (or a		-						-
Examiner				Isch		Coli	tis					
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	J "	Due to (or a	s a conseq	uence of):	system f	atur				
ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a	s a conseq	uence of):	1957 cm 1	par ave				-
The COLORS, P.O. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	calE			Seps								
oo tificate	edi		G.									
th cert tendin or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1	f yes, outcom I □Live birth	2 🗌 Feta	l death	3 □Ectopic pregnanc	у			23d. Date of Month	delivery Day Year
the all	ysici	1 Yes 2 No 9 Unknown		4□Pregnant 9□Unknown	at time of d	leath	5 ☐ Other (specify) _					
that the	by Ph	Part II. Other significant condi		uting to death	but not res	ulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
w requires to the second second be s		De hydret	ion						1 🗆	Yes 2	□No 3 □	Probably 4 Unknown
law re as bec	ompleted		_						24a. Wa aut	opsv	prior	autopsy findings available to completion of cause of
	O									_	1 🗆 Y	es 2□No
vital sicien: 1 certifical lirector, p	o Be	25. Was case reterred to medic examiner? 1 Yes 2 No	Hosp	ital: 1 Hnpa	tient 2	FR/Outpa	tient 3 DOA Ot	hor	ath (Check only Home 5 ☐ Res		6 □Other (S	pecify)
g Physical disperse d	-	27. Manner of Death Natural 5 Pend		8a. Date of In	njury	28b. Tim	of 28c. Inju		28d. Describe			
ISION OT Itending Phy death. ctor: After this y the funeral of	catic	2 Accident inve	stigation]Yes 2 □No	29f Location	(Street an	d Number of	Rural Route Number,
LIVISION I or Attending after death. Director: Afte	Certification:		mined 2	building,	etc. (Specia	ome, tarm, fy)	street, factory, office			own, State		Tigral Floate Nambor,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifi	ring Physicie	n: To the be	st of my kno	owledge, d	eath occurred at the to	ime, date and place	e, and due to the	e cause(s)	and manner	as stated.
the Ho in 24 I the Fu	Medical	one)		and manner		ation and/o		se number	aried at the time			onth, Day, Year)
To the within To the compl	2	29b. Signature and title of o	Cu	M	1)	M	/ \	55712		250. 50	1281	2005
		30. Name and addr of person	on who compl	eted cause o	f death (Iter	m 23a) (Tv				,	1001	2003
		Eric Je	Widh	naicr	MO.		503 By	ru St.	Cambri	age,	MU	21613
Sta		31. Date filed (Month, Pay Xe	3 1 20	05 ^{32. Reg}	rar's Sign	ature	Ante					
Regist	di.			7			The same of the sa					

DHMH 17 Rev 1/2001

	Physici	an	1 - State Amend Item 1. Decedent's Name (First, Middle, Last DAVID)			incatt	01 1	Journ		2. Date of De Month June		2ڵڽ	შ5	3. Time of D 5:25	
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Fown, or	Location of	of Death	- Curic	4c.	County of E		3.23	77 (4)
	Exami	iei	VA Maryland Health						Point				Cecil			
	Funeral		Social Security Number 6. Se		7. Age (In yrs.	* *	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)		Birthpla	ace (State or F	Foreign
	Director		216-24-9468 XU	X M 2□F	74	Yrs.					1/30/	1931	M		<i>l</i> and	
3	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10	d. Inside City	Limits
VID	Mary a-1 sh	tor	PA York			Delta									1 X X es 2	!□No
BRADLEY, DAVID 036	d within 72 hours after death with the Maryland jene. Ir than "natural", or Itams 23s or 28s-f show The Medical Extening to usit be incillisted	al Director	10e. Street and Number 322 Main S	t			10f. Zip		314				zen of What	Count	ry?	
)LE	ams 2	Funerai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Deced	ent of Hi	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 1	14. Race - A			
RAI 36	hours after tural', or Ita	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Pivorced	ty⊃yyes If Yes, Giv	2□No e ates: Kor	ļ	1□Yes 2		Specify:	,	, , , , , , , , ,		Specity(h			
9 P	tural	ed b	15. Decedent's Edu		ates: KOL	16a. Dece	dent's Usua	l Occupa	ation				nd of Busine			
n: 215	within 72 ene. than "nai	piet	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1	-4or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired	during most)	t of workii	ng				,	
;ia 21	filed wit Hygiene othar tha	Completed	12			Pipe	Fitt	er					stru	cti	on	
sic	be dala	Be	17. Father's Name (First, Middle, Last)	D							(First, Middle,					
o Physician: BRA <mark>Maryland 21215-0036</mark>	should by nd Menta marked	T _o	Andrew Thomas 19a. Informant's Name/Relationship (T)		еу	10h Maili	na Address	(Stroot		tru	de Williams	111i		n Zin (Co do)	
to I	S a s		Timothy J. Brace		son						1ta, I			θ, <i>Ζ</i> Ι <i>ρ</i> (.voae)	
ē,	s 1 and 2 f Health item 27 othar tra		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	e of			ate		cation - City	or Tov	vn, State	
known altimore	Pages ient of nt: If i		1 XBy ria 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)		State	-		,		6/	10/05	De	lta,	PA	17314	
s known t Baltimore,	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service Licens	999	-	L 22	2. Name an	Addres	s of Facilit	y	-1+-				-	
Name Ba	88 58		(Jeffrey S.	well	10						elta,		1/31	4		
Na Pa			23a. Part1. Exter the disease, or comp shock, or heart failure. List only o	lications that can be cause on ea	ach line.	h. Do not ent	er the mode	of dyin	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Betwe Onset and De	en
	Physician /Medical	Ž.	Immediate Cause (Final disease or condition resulting in death)	Lur	ng Canc	er									nknown	atii
	Examiner			Due to (or as a conseq	uence of):										
	4- 1	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):										
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8760,	ate hy	dicai		d							-					
) ×	leath certific attending p	/Me	IF FEMALE:	23c. If yes, out	come of pregna	incv	-					2	3d. Date of	dolinos	*	
Вох	Jeath atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live bi	irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pro						Month		y Day Yea	ar
P.O.	t the c by the	hysi	9 Unknown	9□ Unkno	own						·					
S,	w requires that the di been signed by the should be detached	by P	Part II. Other significant conditions co	ntributing to de	eath but not res	ulting in the u	nderlying ca	use give	en in Part I.						cause of dea	
ord	requir sen si nould										1 D Y	'es 2 □]No 3	Proba	bly 4. ZHUnk	cnown
ec	e law has b	Completed									24a. Was autop	sy	24b. Were prior	autops to com	sy findings ava pletion of caus	ailable se of
a H	sician: The la certificate ha rector, page 2											med? No	death	'es 2	!□ No	
Vit.	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2	ER/Outpatier		Othe	ar.		(Check only o		T0# (6			
o	g Physer this eral di	n: To	27. Manner of Death		of Injury h, Day Year)	28b. Time of		Bc. Injury Work			ne 5 Resid			респу		
ion	ath. rr; Aft	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(MONE	n, uay rear)	Injury	М		r Yes 2□1	No						
Division of Vital Records,	r Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place buildir	of Injury - At hong, etc. (Specif	ome, farm, str	eet, factory	office		2	28f. Location (S City or Tow		Number or	Rural	Route Numbe	f,
Q	urs af			C1.1												
	To the Hospital or Attanding F within 24 hours after death. To tha Funeral Director; Atter completely filled in by the funer.	edical	29a. Certifier 1	iner: On the ba and mann	asis of examina	wiedge, death tion and/or in	n occurred a vestigation,	it the tim	ne, date and pinion, deat	d place, a th occurre	and due to the o ad at the time, o	cause(s) a date and	and manner place, and o	as sta due to t	ted. he cause(s)	
	Fo the within Fo that comple	Med	29b. Signature and title of certifier				29c	License	number			29d. Date	signed (Me	onth. D	ay, Year)	
			1 Tomile	en n	- Br		D	302	72			6/7/	05			
	22		30. Name and address of person who co													
	20		Thomas Miller, M.I		Marylan			re S	ystem	ı Pe	rry Poi	.nt,	MD 2	190	2	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 3 2005	Eletero Silver	egistrar's Signa	Cooke										

		-	For State Registrar	State of I	Maryland /	•	irtmen <i>tificat</i>				ental <u>l</u>		ene . No?]	05	10001
			Decedent's Name (First, Middle, La	st)							2. Date o			U U	3. Time of Death
	Physicia		Rowland Clay	Brandenbi	ıra					l.	Month June		Day 1	2005	5:00 A.M.
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of	of Death			4c. Coun	ty of Death	
			905 Dewey Avenue					Ha	gerst				Was	hingto	on County
	Funeral		5. Social Security Number 6. S	Sex 7. M 2□F	Age (In yrs. last		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of	Day Y	(ear)		place (State or Foreign
	Director		217-16-2721	IVI ZUI	83	Yrs.				1	May	14	1922	Mai	ryland
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation								I Od. Inside City Limits
	Maryi f sho ied a	5	Maryland Washi	naton	п	lagers	etown	1							1 X Yes 2 ☐ No
	the 28a	Directo	Maryland Washi 10e. Street and Number	ngcon		agera	10f. Zip					100	g. Citizen of	f What Cou	ntry?
	3a or		905 Dewey Ave.					217	42				Unit	ed Sta	ates
	deeth with the Maryland me 23s or 28s-f show	Funerai	11. Marital Status	12. Was Decede		13. V	Nas Dece	dent of Hi	spanic Ori	igin? (Spe	cify Yes o	r No-		ace - Ameri	
٥	after or ite		1 Never Married 2 Married	1 XYes 2			1 🗆 Yes		Specify:		mount of	•,	Spec	ack, White, Wh	íte
3500-G1212	be filed within 72 hours after deeth with the Marylan Hygiene. 4 Hygiene. 4 other than "natural", or iteme 23a or 28a-f show other than "natural", or iteme 23a or 28a-f show event, the Macifical Examinar must be natified at	d by	3X Widowed 4 □ Divorced	Year or Date	es: 										
7	"nati	Completed	15. Decedent's E (Specify only highest gr	ducation a <i>d</i> e co <i>mpleted)</i>	1	16a. Deced (Give	tent's Usu kind of wo DO NOT u	rk done o	luring mos	st of workir	g	16	Sb. Kind of	Business/In	dustry
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	filed within 72 Hygiene. other than "natent, the Mudic		17. Father's Name (First, Middle, Last	4		- COI	illac	/			(First, Mi		aiden Suma		MI W.
a	buld be Mental arked o	To Be	Clay K. Brande	nburg					E	leano	r F.	Sti	ne		
Maryland	permit. Pages 1 and 2 should be Department of Heelih and Menia Important: if item 27 is marked any injury or other treumatic evonce.	-	19a. Informant's Name/Relationship											n, State, Zij	
_	and 2 Belith a m 27 is		Dennis C. Brand	lenburg (:	Son)	P.O	. Box	202	4 Hag	gerst	own I	Mary	land	21742	-2024
ē,	s 1 a of Hei item		20a. Method of Disposition	70	cem	e of Dispo	natory or	me of other plac	e)	D	ate	20	Oc. Location	n - City or T	own, State
Ē	Pages nent of int: if its iry or o		1 XBurial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci		Rest	Have	en Ce	mete	ry J	June	4 05		Hager	stown	Maryland
Baltimore,	permit. Departminents imports any injuited once.		21. Signature of Poperal Service Lice	ensee	2	22	2. Name a	nd Addres	s of Facili	ity Dou	glas	A.	Fiery	Fuen	ral Home
m	88 5 8		1 Janiel	O. fai	Wey, I	<u>~_ 1:</u>	331 E	Caste	rn Bl	lvd.	N. Ha	ager	stown	Mary	land 21742
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on eac	used the death. In line. IS BROV2							ory arres	et,		Approximate Interval Between
	/Medical		disease or condition resulting in death)	a	r as a consequer						•				
	Examiner		Sequentially list conditions,	b											
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8760	cate be executed physician and the burial-transit	dicai	•	d											
9 ×	The law requires that the death certificate be executed ate been signed by the attending physician and cage 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnanc	v							234 [Date of deliv	erv
Вох	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fetal dent at time of deat	eath 3	☐Ectopic p☐Other (s							vionth	Day Year
Р. О.	that the de led by the a detached	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov				,,,,,							
	that ned by deta	by Pf	Part II. Other significant conditions	contributing to dea	ith but not resulti	ing in the u	inderlying	cause giv	en in Part	I.	23e.	Did toba	cco use co	ontribute to	the cause of death?
ds,	n signe	Q P										1 🗌 Yes	2 □ No	3 ☐ Pro	bably 4 Unknown
00	w requir s been si should	Completed										Was an	241	o. Were aut	opsy findings available
Re	The lav	шо									101	autopsy perform	ed?	death?	ompletion of cause of
Vital Record		a)	25. Was case referred to predical						26. Plac	e of Death			<u>, </u>		
	d is	To B	examiner?	Hospital: 1 🔲 In	patient 2 EF	R/Outpatie	nt 3 D	OA Oth	er: 4 🗆 N	ursing Hor	me 5 🖻	Resider	nce 6 🗆 C	Other (Speci	fy)
0	Jing Ph n. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month	Injury 2: , Day Year)	8b. Time o	of	28c. Injur Wor	y at k?		28d. Desc	ribe hov	v injury occ	urred	
0	Attending or death. ector: After by the fune	atic	2 Accident investigati				М		Yes 2						
Division of	r Atte	Certification:	3 Suicide 6 Could not determine	d 200. Flace	of Injury - At hom g, etc. (Specify)	e, farm, st	reet, facto	ry, office		1		ion (Stre or Town,		mber or Rui	al Route Number,
	To the Hospitel or Attending i within 24 hours after death. To the Funerel Director: After completely filled in by the funer														
	Hosp 4 hou Fune ety fil	edical	(Check only 2 Medical Exa	Physician: To the taminer: On the bas	sis of examinatio	edge, deat in and/or in	th occurred rvestigatio	d at the tir n, in my o	ne, date a pinion, de	nd place, a ath occurr	and due t ed at the	o the car time, da	use(s) and te and plac	manner as : e, and due !	stated. to the cause(s)
	To the Hospitel within 24 hours a To the Funeral Completely filled	Med	one) 29b. Signature and title of certifier.	and manne	er stated.		20	9c. Licens	e number			29	d. Date sig	ned (Month	, Day, Year)
	To To	-	250. Signature and titled to certified	Pomo	xal Phy	(n		1	1	2016	SOE		_		
7			Vous prus	1010	,	1141	an		JU	$\omega \iota$	10		10	ne.	3 2005
5	0+1		30. Name and address of person wh		of death (Item 2		37		Had	genr	torus	10	MI	21;	142
	_	ate	51. Date filed (Month, Day, Year)	000E 32. Rg	gistrar's Signatu	re	1	•	1040	1		-	(100		
	Senist		JUN 0 3	2005	agree 1	4. 6	Toute		,						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5: 40PM **Physician** 25/05 05 Albert A BELMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Aprilo73 ilver Spring FIELD RO MONTGOM ERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 88 WISCONSIN 0720 Yrs. 08/29/19/6 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Silven SPRING 1 ☐ Yes 2XNo WD MONT Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 209 04 1650 15D 1761 107 GRACE 3122 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, While, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) GOV AT DEDT OLLABOR 54 18. Mother's Name (First, Middle, Maiden Sumame) injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be SAPOSS DENA BELMAN SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 20 E. CALLS OR RULL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State and Number or Rural Route Number, City or Town, State and S 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other traugongs. Kobert Belman 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/26/05 WASH, D.C 4 Donation 5 ☐ Other (Specify) GEORGE WACHINGTON 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007; Washington, D.C. of Funeral Service Licen Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTON DUEASE Physician ORONARY Due to (or as a consequence of) WRITERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Medicai IF FEMALE

/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Division of Vital Records, P.O. Box 68760, attending physician within 24 hours are: ____ To the Funeral Director

rai', or itams 23a or 28a-f show Examiner must be notified at

natural

is marked other than "naturalmatic event, the Medical

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 □Ectopic p			23d. Date of delivery Month Day Year
by	Part II. Other significant conditions co		sulting in the underlying	cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 25No 3 □ Probably 4 □Unknown
Completed	Abdominal A	OFTIC AND	rusem		24a. Was an autopsy performed?	
0	25. Was case referred to medical			26. Place of D	eath (Check only one)	
O B	examiner? 1 ☐ Yes — 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	Other: 4 Nursing	Home Residence	6 ☐Other (Specify)
atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	jury occurred			
ertific	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Street City or Town, Sta	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
dical C	29a. Certifier Check only one) Certifying Ph	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)			
0			2	Oc. License number	29d.	Date signed (Month, Day, Year)

State Registrar

TAPE, mp 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

um OREHARD DR. 12201 PL Registrar's Signature

		1 - For State Registrar	State of Marylan		artment of H			giene Reg. No. 🤈 🎧 🎵	15 10500
Phys /Me	ician dical	Decedent's Name (First, Middle, Last)	Pear1	В	ERG		2. Date of Dea May 25		3. Time of Death 3
Exan		4a. Facility Name (If not institution, give st 4025 Fulford Stree	t		4b. City, Town, or Oln	ey		4c. County of	
Funera Directo		5. Social Security Number 6. Sex 053-16-2035	7. Age (In yrs. 9		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year) 0, 1914	New York
e Maryland ia-f show	ctor	10a. State 10b. County Maryland Montgom		y, Town or Lo	cation r Spring				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
uth with th	Funeral Director	10e. Street and Number 14510 Homecrest Roa	d #2021		10f. Zip Code	0906		10g. Citizen of Who United S	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Iniportant: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. It a Medical Evan their mast be notified at	by Fune	11. Marital Status 1 Never Married 2 Married 3 V Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi fYes, specify Cuba I□Yes 2⊡ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. white
within 72 ho ene. than "natur	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give life. l	lent's Usual Occupa kind of work done of DO NOT use retired Solicitor	turing most of wa)	orking	16b. Kind of Busin	sociation
Man yieling Z.I.Z. 13-0030 d.2 should be filed within 72 hours af th and Mantal Hygiens and an an an an an an an an an an an an an	To Be Co	17. Father's Name (First, Middle, Last) Jacob Gree	nberg			18. Mother's Na	me (First, Middle, Ky Katuch	Maiden Sumame)	
and 2 should eath and Men m 27 is marke	-	19a. Informant's Name/Relationship (Typ Roberta Greif, Daug	e, Print) hter	19b. Mailir 4025	g Address <i>(Str</i> eet a Fulford S	t., Olne	ural Route Numbe	or, City or Town, Sta 20832	ate, Zip Code)
Deficiency of the particular of the perturbent o	Ø	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Othar (Specify)	moval from State Jud	emetery, cren dean M	sition (Name of natory or other placemorial G	ardens	26/05	20c. Location · Ci Olney, M	
permit. Departr Importe	- Suce	21. Signature of Funeral Service Cicenser 23a. Part1. Enter the disease, or complic		To	. Name and Addres orchinsky 54 Carrol	Hebrew			C 20012 Approximate
icate be executed Washician and physician and street be be executed that is the burial-transit property of the purial-transit Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that miliated events resulting in death) Last	Due to (or as a consequence to	uence of): uence of):	Carcinom	a			Interval Between Onset and Death	
the death certify the attending iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√ No 9 ☐ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
The law requires that te has been signed by age 2 should be deta	b	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.			ute to the cause of death? Probably 4 □Unknown
- 00 11	Completed						24a. Was autop perfor 1 Yes	an 24b. We sy prior dea 2 XNo 1	re autopsy findings available or to completion of cause of th? Yes 2 No
ng Phys ter this	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing I			(Specify)Daughter's Residence
Ital or Attending irs after death. ral Director: Afte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	/) 			City or Tow	m, State)	or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	one)	cian: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation, in my or	oinion, death occ	urred at the time, o	date and place, and	d due to the cause(s)
2 still to the state of the sta	Σ	29b. Signature and title of certain	ela -	20	D 35			May 25,	
		30. Name and address of person who co	, MD 1811	l Princ	ce Philip	Dr., 01	ney, MD	20832	
Regi	State strar	31. Date filed (Month, Day, Year) MAY 2 7 2005	2. Registrar's Signa	ture	le le				

			1 - For State Registrar	State of Ma		partment d ertificate		and Mental I	Hygien Reg. N	2005	19634
	Physici	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of Month	D	ay Year	3. Time of Death
	/Medic Examir		Kermit Ivon Bass 4a. Fecility Name (If not institution, give	e street and number)		4b. City, Tov	wn, or Location	May of Death		c. County of Death	3:50 P ^M
			Anne Arundel Medi	cal Center		Annapo	lis		A	nne Arun	ie1
	Funeral Director		5. Social Security Number 6. S	13714 2 T E	(In yrs. last birthd 92 Yrs	Months D		24 Hrs. 8. Date of (Month, 03/24	Birth Day, Year	9. Birthp Cour	place (State or Foreign htry) Carolina
	ס		577-07-8788 Usual Residence of Decedent	,	72			03/24	/1913	NOTE	l Carolina
	filed within 72 hours after death with the Maryland Hyglene ther than "naturel", or flems 23e or 28e-1 show ther than Badical Exeminar must be notified at out, the Madical Exeminar must be notified at	7	10a. State 10b. County		10c. City, Town or					1	0d. Inside City Limits
	the M	recto	Maryland Anne Aru	indel	Davidson	VILLE 10f. Zip Co	ude.		100.0	itizen of What Cour	1 ☐ Yes 2/☐ No
	h with	al DI	1119 Mt.Airy Road			21035			USA		iuy:
	tems tems	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1	3. Was Decedent	of Hispanic Or	igin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - Americ Black, White,	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	'	1 ☐ Yes 2 🔀				Consitu	
21215-0036	72 hounature	Completed by Funeral Director	15. Decedent's Ed	lucation	16a. De	cedent's Usual O	ccupation		16b.	Whit	
2	nithin 7.	mple	(Specify only highest gra	College (1-4or 5+)) (G	ive kind of work d e. DO NOT use n Presiden	one auring mos etired) 1 t of	st of working	_		
d 2	Hygie Hygie other t	CO	12 17. Father's Name (First, Middle, Last)		Wash	ington C	ab Comp	oany er's Name (First, Mid		nsportati	_on
<u>lan</u>	Aental Aental rked c	To Be	Jonathan Bass					hia Lamm		oumano,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Madical Eventinet must be notified at Once.		19a. Informant's Name/Relationship (**				er or Rural Route Nu			
ė,	1 and Health em 27		Cindy Beales/ Net 20a. Method of Disposition	ce				l Davidson		ocation - City or To	
Baltimore,	Pages ent of nt: If it ry or o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	Cometery, C NOT	sposition (Name of Gramatory or other thern a Cremate	r place)	05/25/2005	1		
alti	ppartm porte y inju		21. Signature of Funeral Service Licer		VILGIIII			y Robert E			
<u> </u>	8 ⊊ 2 2		full					Road Bow		D 20715	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com sock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	consequence of):	Sladd		Cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
,8760,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, 5.7, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
687	tificate ig physi as the l	edical		. d	250,0001						
O. Box	death cer e attendin id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tii 9 Unknown	Fetal death	3 □Ectopic pregn 5 □ Other (specif			-	23d. Date of delive Month	ory Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the	e underlying caus	e given in Part I			use contribute to the	ne cause of death? ably 4 Unknown
al Record		Completed							utopsy erformed?	prior to cor death?	psy findings available impletion of cause of
Z.	Physiclen: this certificatal director,	o Be	25. Was case referred to medical examiner?	Hospital:			04	of Death Check on			
Division of Vital	무무등	∥⊢ "	1 Yes 2 No Pending 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Simpatient 28a. Date of Injury (Month, Day)	28b. Time	e of 28c.	Injury at Work?	ursing Home 5 R)
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, (Specify)			28f. Locatio	n (Street a Town, Stat	nd Number or Rura e)	l Route Number,
	ne Hospita n 24 hours ne Funera bletely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1	ysician: To the best of niner: On the basis of e and manner state	xamination and/or	eath occurred at the investigation, in the	ne time, date ar my opinion, dea	nd place, and due to that the control of the time.	he cause(s	s) and manner as st d place, and due to	ated. the cause(s)
)	To the To the comp	Ř	29b. Signature and title of certifier	and S			cense number	9		ate signed (Month, I	
			30. Name and address of pers in who	completed cause of dea		pe, Print)	we c	hesher	021	669	
	Sta Registi		31. Date filed (Month, Day, Year)	32 legistrar	s Signature	back !					

		For State Registrar	of Maryland / Depa	artment of Hortificate of L			ene 005	19635
Physici		 Decedent's Name (First, Middle, Last) Ruth Elizabeth Bollma 	n			2. Date of Death Month May	Day Year 22, 2005	3. Time of Death 4:15 p M
/Medio		4a. Facility Name (If not institution, give street and r Ginger Cove: Health Ce		4b. City, Town, or	Location of Death		4c. County of Deat	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs. last birthday) 89 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 30	Year) 9. Birtl	hplace (State or Foreign untry) MD
ryland thow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
the Mg	ecto	MD Anne Arundel 10e. Street and Number		Annapo	olis	10	g. Citizen of What Co	1 ☐ Yes 2√∑ No
h with	al Di	4000 River Crescent Ro	ad	214	01		US	
partitioney, Marylattia Z. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23a or 28a-1 show any injury or other traumatic svent, the Marical Examinational be notified at once.	by Funeral Director	Armed	s 2⊠No Give	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Spent, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
vithin 72 ho	Completed		(Give (1-4or 5+)	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ing 1	6b. Kind of Business/	
drice filed vontal Hygie	se Co	12 17. Father's Name (First, Middle, Last)	SC	hool Teac	18. Mother's Name			SCHOOL
Tylcar nould by d Menta narked natic sy	To B	Edward Ay	40h M-11			tha Leri		
INCL nd 2 st alth and 27 is n or traun		19a. Informant's Name/Relationship (Type, Print) Roger A. Bollman/Son		ng Address (Street a			City or Town, State, Z	(ip Code) 21601
Des 18 Tof Hear		20a. Method of Disposition 1 ☐ Burial 2 【3 Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	May	24	20c. Location - City or	
DEMILITION Definit. Pages Department of mportant: If it any injury or o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Metro Cr		2	005	Baltimore,	
		Momy FALLE	w 4	arranco & 95 Gov. R	itchie Hw	A. Sever y, Sever	na Park Fi na Park, N	neral Home D 21146
		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final	t caused the death. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death)	o (or as a consequence of):					6 m
Examiner	-e	Sequentially list conditions, bb	o (or as a consequence of);					
cuted nd transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
e be exercian a	dical Ex	resulting in death) Last Due t	o (or as a consequence of):					
ortificate ing phy e as the	Medic	IF FEMALE:						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant 12c. If yes, o	gnant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
quires that quires that en signed b	by	Part II. Other significant conditions contributing to				23e. Did tob	acco use contribute to s 2 XNo 3 □ Pre	the cause of death?
I RECOLUS, The law requires the has been signed page 2 should be to	Completed					24a. Was an autopsy perform	/ I prior to d	topsy findings available completion of cause of
VICAL siclan: 1 certificat irector, p	o Be	25. Was case referred to medical examiner? 1 Tives 2 Tives Hospital:	The state of the s	Othe	26. Place of Death			
ng Phy fter this	 	The second secon	Inpatient 2 ER/Outpatient e of Injury 28b. Time of Injury 28b. Time onth, Day Year)	III 3L DOA	at ursing no	me 5∐ Resider 28d. Describe ho	nce 6 Other (Spec w injury occurred	cify)
OVISION Tor Attending after death. Director: After the function by the function.	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, st Iding, etc. (Specify)		res 2 □ No	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Spital cours af	O	29a. Certifier 1 ☐ Certifying Physician: To	he best of my knowledge, deat	h occurred at the tim	e, date and place.	and due to the ca	use(s) and manner as	stated
the Hos in 24 h the Fur	ledical	(Check only 2 Medical Examiner: On the one) and ma	basis of examination and/or in anner stated.	vestigation, in my op	inion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
with To Con	Σ	29b. Signature and title of certifier		29c. License	number 1476		od. Date signed (Month $5^{2}-23-2$	
		30. Name and address of person who completed ca					5 27 0	, ,
St	ate		Peninsula Farm 1	Road, Arno	old, MD	21012		
Regist		MAY 2 4 2005	Brance & A	carte				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** ALLISON JANE BENNETT 2,2005 JUNE :50A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NEWBURG
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11345 MT. VICTORIA ROAD CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2QF Yrs. 213-94-2649 39 AUG.8,1965 WASHINGTON, DC Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "naturel" or Items 23s or 28s-f show traumatic event. Its Medical Examine member by notified at NEWBURG 1 ☐ Yes 2 X No MD CHARLES Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20664 11345 MT. VICTORIA ROAD 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ♥ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) 1 other than " liled within Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOY CAREGIVER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 ts marked c MARTHA COOKSEY JAMES ALLAN BENNETT, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA BENNETT-MOTHER P.O.BOX 189 COBB ISLAND, MD. 20625 f Health i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6-6-05 EPIS.CEM. CHRIST WAYSIDE, MD. injury M00479 22. Name and Address of Facility A L S LA PLATA, MARILAND 21. Signature of Empral Service Licensee SERVICE, P.A. eny ir her 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Shut disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Year Day 4☐Pregnant at time of death 5 Other (specify) 0.0 detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 2 No Physician: 25. Was case referred to medical examiner?

1 Yes 2 \(\subseteq \text{No} \) the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural after death. 10:50 AM 1 Yes 2 No wound 612105 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide Newburg 11345 Mt. Victoria Pd Home 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 184001. D0050883 yuna YAHIA M. TAGOURI, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PL Laplacon WINRSUM 11655 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 SOFIA CASALINI May 24, 3:05 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗓 F 126-24-8124 Director 86 1919 Colombia May 14, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Md. Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20401 Ryecroft Court 20886 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or item any injury gr-other traumain. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Colombian Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Luis Felipe Ruiz Emma Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20401 Ryecroft Ct. Montgomery Village, Md. 20886 Marta S. Goldstein (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State May 26. Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 2005 22. Name and Address of Facility 21. Signature of Funeral Service Licenses DeVol Funeral Home urtis 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician S-Ensi disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last certificate be exec Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 X No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 1 Unknown been a 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred el or Attending P s after death. After Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director; 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mr 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMEND 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Cappeta, ARthur W. Baltimore. Marvland 21215-0036

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	Physicia /Medic		Arthur Wade Cappetta					MAŸ		005	6:27 PM M
	Examin	er	4a. Facility Name (If not institution, give street and nun	iber)			r Location of Death		4c. County	of Death	
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	h with th	al Directo	10e. Street and Number 4017 Spring Valley Drive			10f. Zip Code	0695		10g. Citizen of	What Cour JS	try?
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gaitimore	ages 1 nt of H t: If iten / or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 3			Disposition (Name of , crematory or other place Crematory	_{св)} ; 5–29-1	Date 05	Waldon		
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			1 - For Stete Registrar	State of Maryla		artment of F			ene2 () () 5	19640	
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month						Day Year	3. Time of Death	
	/Medi		John Joseph Comeau May 21, 2					2005	10:57 P ^M		
	Examir	ıęr	4a. Facility Name (If not institution, give Anne Arundel Med:				r Location of Death	1	4c. County of Death		
	Funeral				s. last birthday)	Annapo If Under 1 Year	11S If Under 24 Hrs.	8. Date of Birth	Anne Arui		
	Funeral Director		014-10-9649 Usual Residence of Decedent	7. Age (In yn 91	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) June 29	,1913 Mass	place (State or Foreign intry) Sachusetts	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show important: If item 27 is marked other than "natural", or items 23s or 28a-f show arry injury or other traumatic event. I've Medical Exatricinal countries could be a page.	ctor	Mass. 10b. County Essex		Oc. City, Town or Location Haverhill				10d. Inside City Limits 1 ☐ Yes 2 \(\frac{1}{2} \) No		
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		by Funeral Director	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▓ No		pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	, etc.	
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12	lled w tygier har th	Cor	17 Esther's Name (First Middle Leat)	Leat		her Work				her Preparation	
, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Monee.	To Be	17. Father's Name (First, Middle, Last) Hillary Comeau		_		Emma I		·		
			19a. Informant's Name/Relationship (T) Constance E. Con					ra/Route Number, (verhill,	City or Town, State, Zij Ma. 01832	· ·	
nore			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 🕅 1 □ Donation 5 □ Other (Specify,			esition (Name of matory or other place ck's Cem			oc. Location - City or To everhill, M		
Baltimore,			21. Signature of Funeral State Cens		22	2. Name and Addre	ss of Facility $G\epsilon$	eorge P. K	alas Funer	al Home	
	1000		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o		d. Edgewater, Md. 21037 atory arrest. Approximate Interval Between						
Physician / Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) a. / W & ess Electral Atturity Due to (or as a consequence of):							Minites Clayp				
l Records, P.O	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ed by Physiclan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3]Ectopic pregnancy] Other <i>(specify)</i>	,		23d. Date of deliv Month	ery Day Year	
			Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	he cause of death?	
		Completed						24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of	
Vita		Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only one)			
of		tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?			ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
Division		Certification:	2 ☐ Acdident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	the Ose Blood of Injury. At home form should feel the				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		edical C	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannary of the date and place, and mannary of the date and place, and mannary of the date and place, and mannary of the date and place, and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and mannary of the date and place, and due to the cause(s) and due to the cause							stated. the cause(s)	
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			on Name and address of person who c	2001 me	dical	Parker	cry &	thnajol	lo Mo	2005	
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			for State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of L			iene	5 1	9641
	Dharisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month		Year	. Time of Death
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Ĕ	Pages thent of I tant: If its jury or o		`4 ☐ Donation 5 ☐ Other (Spec	oify)		Memorial P		27/2005		ver, M	D
Ball	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Lic	< H . H	111	22. Name and Addres		Stewart F			010
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Division of Vital Records,	il or Attanding P after death. I Director: After i I in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)			treet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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	lo tha Hos within 24 h To tha Fur completely	Med	29b. Signature and title of certifier	and marrier su	atou.	29c. License	number	29	d. Date signed	(Month, Day,	Year)
}	⊢ s ⊢ ō		M las		n		MD 3160)2	May 2	26, 20	05
1	(2)		30. Name and address of person wh	o completed cause of c	death (Item 23a) (Type	e, Print)				, 20	
1			Michael Gu			chigan Ave	., N.W.	Wash., Do	20010	0	
	Sta		31. Date filed (Month, Day, Year)	Registr	rar's Signature	2000			-		
	Registr	ar	MAY 3 1 20	os poere	No HO						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Hadia Hannah Conteh /Medical 2005 2:59 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 6017 Sellner Lane Clinton If Under 24 Hrs Prince George's 9. Birthplace (State or Foreign Country)
Freetown, S.L. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. **Director** 632-88-5070 11/13/1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or items 23a or 28a-f ehromany injury or other traumatic event, ILE Marked ST. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6017 Sellner Lane 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ibrahim Karoma P Famatta Kabba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kadiatu Lowe/ Daughter 6017 Sellner Lane Clinton, MD20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 5/29/05 Othe (Specity) Adelphi, MD 4 Donation 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Fune Service Licensee 7474 Landover Rd. Landover, MD 20785 Part 1. Enter-the-disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cance Pancreatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 🙀 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding Injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation the Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funaral 29a. Certifier Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2226 William and Mary Dr. Alexandria Vt 22308 Irwin 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 1 2005

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** May 28, 2005 10:10 AM Margaret Sturm Conner /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Ocean City 14 82nd Street Worcester 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □X Director 055-38-0579 1/11/1914 New York 91 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1**X**Yes 2 □ No Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 14 82nd Street 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene importent: If Item 27 is marked other then any injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Family Caregiver Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **Andrew Sturm** Florence Wilke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bishopville, MD 21813 Lynne C. Gillen 12314 Dixie Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Othey (Specify) 6/1/2005 Parsons Cemetery Salisbury, MD 21. Sign while of Filleral 22. Name and Address of Facility The Burbage Funeral Home Berlin, MD 21811 108 William Street Part I. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each 23a. Part I. Enter death. Do not enter the mode of dying. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner burial-translt Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 27 No. P 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 desidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; After To the Hospital or Attending 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Moi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HENRiette OS *30* 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death workester HURTLEY 10 co make 144 Munder 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Days 1 M 2 V 242 - 34-466 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No CCUM Ack HORNBULL 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 Married 1 Tes 2 No 1 Never Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restruc OOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Custon 1650 ANNAbelle 19a. Informant's *ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wavlen 20b. Place of Disposition (Name of cemetery, crematory or other place) HEENTOWN VA 23791 hRistofher 20c. Location - Jity or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) 6-4-05 TaborNACIE CH. Com. HERNTON 22. Name and Address of Facility WH ARTON FUNDED 21. Conatule of Funeral Service Licensee de ACCOMAC 2017/ WhARTEN 23a. Part 1. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23361 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) menta Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Liscase of Figur) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Funeral

Director

rai, or items 23a or 28a-f show Examiner must be notified at

by Funeral Director

Completed

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death with the Maryland

2 should be filled within 72 hours after on and Mental Hygiene. Is marked other then "natural", or Itel

it of Health if item 27 I

traumatic event, the Medical

ŏ permit, Pagé Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Examiner attending physician and for use as the burial-transit Physician/Medical detached þ Completed Be 2 Certification; in by the I

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Death

1. Natural

29a. Certifier

2 Accident

31. Date filed (Month,

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Dav

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 Ø No

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an autopsy performed? 2 No

1 ☐ Yes

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \)

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D54422 29d. Date signed (Month, Day, Year) 5-30-05

30. Name and address of person who completed cause of death (Item 23a) Type, Print) Vlanket 60

5 Pending investigation

010m gistrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

: After

Director:

death.

To the Hospitel within 24 hours a To the Funerel I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)

For State Registrar

within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4. Facility Among Price shadowing you areas and created in 1962 Lindancor Drive 1962 Lindancor Property 1962 Lindancor L		Physici /Medio		Philip Peter DiM	laggio				28 2005	7:45 A M
Some all south Number Some all south Number 2.0 sex 17. Ago (6 yr. Nam Cohnay 11/1000						4b. City, Town, o		4	•	
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The second process of the second process of		th with the	al Dire		rive	10f. Zip Code	21401	10g. (•
Compared to the control of the con		eme	ner	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of I	Hispanic Origin? (Speci	fy Yes or No- can, etc.)		
The second of the second of	9036	ours afte	þ	_	1 X Yes 2 □ No WW II				Specify:	White
Compared to the control of the con	5-0	72 h "natu	ete	15. Decedent's Ed (Specify only highest gra	ducation 16a. Dece ade completed) (Give	edent's Usual Occup a kind of work done	pation during most of working	16b.	Kind of Business/Ind	lustry
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Physician Medical Examiner Togother by the proposed of the pr	Je,	s 1 a of Hea item			comotoni nic	osition (Name of ematory or other pla	ice)		Location - City or To	wn, State
Physician Medical Examiner Togother by the proposed of the pr	E	Page nent c			(y) Lakemont	Mem. Gar	dens 6/1/2			
Physician Medical Examiner Topportunity to propose a property to propose a propose and property to propose a property to propose a property to propose a property to propose a property to property to propose a property to propose a property to pr	a	mit.		21. Signalus - Trineral Service Licer						
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Physician (Medical Examiner) The proposed and suggesting interconditions and place an				shock, or heart failure. List only	plications that caused the death. Do not er one cause on each line.	nter the mode of dyi	ng, such as cardiac or	respiratory arrest,		Interval Between
Sequentially list conditions, and the list of the sequence of list of the sequence of list of				disease or condition		ic pro	STATE	CANCE	R	3 years.
The part of the pa	1			1	Due to (or as a consequence of):					′
The part of the pa			e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):					
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24a. Was an autopsy parformed? 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical spring to completion of cause of death? 26. Place of Death (Check only onl) 27. Manner of Death (Month, Day Year) 28. Was case referred to medical spring to completion of cause of death? 28. Place of Death (Check only onl) 28. Place of Death (Check only onl) 28. Place of Injury at Work? 1 Yes 2 No 29. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and difference of Death (Check only onl) 29c. License number 29d. Date signed (Month, Day, Year) 3 3 1/0 5		ie death ce the attend hed for us	/sician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 2☐Fetal death 3☐ 4☐Pregnant at time of death 5☐					,
24a. Was an autopsy parformed? 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical spring to completion of cause of death? 26. Place of Death (Check only onl) 27. Manner of Death (Month, Day Year) 28. Was case referred to medical spring to completion of cause of death? 28. Place of Death (Check only onl) 28. Place of Death (Check only onl) 28. Place of Injury at Work? 1 Yes 2 No 29. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and difference of Death (Check only onl) 29c. License number 29d. Date signed (Month, Day, Year) 3 3 1/0 5	σ.	that If ed by detac			contributing to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobacco	o use contribute to th	e cause of death?
24a. Was an autopsy parformed? 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical spring to completion of cause of death? 26. Place of Death (Check only onl) 27. Manner of Death (Month, Day Year) 28. Was case referred to medical spring to completion of cause of death? 28. Place of Death (Check only onl) 28. Place of Death (Check only onl) 28. Place of Injury at Work? 1 Yes 2 No 29. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and difference of Death (Check only onl) 29c. License number 29d. Date signed (Month, Day, Year) 3 3 1/0 5	rds,	quires n sign ufd be						1 🗆 Yes	2 No 3 Proba	ably 4 Unknown
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The standard of the standard o	Re	0 4 9	E O					performed?	? death?	
The standard of the standard o	ita	ian: rtifice ctor, p	o l				26. Place of Death (
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Description of the course of t	o L	Ing P		1 Natural 5 ☐ Pending	(Month, Day Year) Injury			d. Describe how in	jury occurred	
Description of the course of t	sio	tendl death. tor: /	cati	2 Accident investigatio	10			f Location (Street	and Number of Dun	Courte Mumber
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)	DΪ	after after Direct	ertif			treet, ractory, office	20	City or Town, Sta	and Number of Abrar	noute Number,
29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/31/05 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)		ara elle	dical C	(Check only Medical Exal	miner: On the basis of examination and/or in	ith occurred at the ti nvestigation, in my	ime, date and place, an opinion, death occurred	d due to the cause I at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
Kaymud E, Bef 100 D36371 5/31/05 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)		Fo the	Me	29b. Signature and title of certifier	0 5	29c. Licen:	se number	29d. [Date signed (Month, I	Day, Year)
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	-						0.1		Λ .	ma 2.44.:

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 3 1 2005

Registrar's Signature

end Item	3 per	Dr.,G84	5,0 <i>H</i> 2	tilicate	hbf [Death		,	Reg. No	20	U 5	1964	
(First, Middle, Las	t)							2. Date of De	eath Da	v ,	Year	3. Time of Death 1:03p.	
Louise D	eLuise							JUNE	2,	200	5	1:30 P	
not institution, give				4b. City, To	own, or	Location	of Death		4c.	County o	f Death		
LUTHERA		GE 7. Age (In yrs. Ia	oot hiethday)	HAGI If Under 1			24 Hrs.	8. Date of Bi	and bo	SHIN		N place (State or Foreig	
20	M 20 X F	82	Yrs.		Days	Hours	Min.	Nov 8	3, Year) 192	2 1	Cou	rland	
Decedent 10b. County		10c. City	r, Town or Lo	cation		-						10d. Inside City Limit	
Washin	aton		Hage	rstowr	1							1 ☐ Yes 2 🔀 N	
ber	90011		nage	10f. Zip C					10g. Cit	izen of W	nat Cou	ntry?	
her Drive	e			21	740)			IJ	nite	ts. F	ates	
		dent Ever in U.S	S. 13.				rigin? (Sp	ecify Yes or N Rican, etc.)		14. Race		can Indian,	
d 2□ Married 1□Divorced	1 ☐ Yes If Yes, Give Year or Da	2 X No		1 □ Yes 2		Specify		· ····································		Specify:			
15. Decedent's Ed fy onfy highest gra	de completed)		(Give	dent's Usual kind of work DO NOT use	done d	lurina mo	st of work	ring	16b. K	ind of Bus	iness/Ir	dustry	
First, Middle, Last)	College (1	-4or 5+)	P	hone A	Asse			e (First, Middle				e Company	
uSing									erine M. Huntzberry				
me/Relationship (7	Type, Print)		19b. Mailir	ng Address (Street a	and Numb	e <i>r or R</i> ur	al Route Numb	oer, City o	or Town, S	tate, Zi	o Code)	
harles D	uSing ((son)	_2072	2 Orio	le	Circ	le H	agersto	wn_M	aryla	nd	21742	
osition Cremation 3 🗆	Removal from 5	ce ce	emetery, crer	natory or oth	er place	e) '							
5 ☐ Other (Specify	<i>'</i>)	Smi	ithsbu	_		- ;						Maryland	
Teral Service Licen	Pa	wey										ral Home land 2174	
e disease, or comp faiture. List only	one cause on ea	ach line,			2			or respiratory a	arrest,			Approximate Interval Between	
Final	Cu	or as a consequ	and	al u	for	di	N					Chonic	
	Due to (or as a consequ	ience of):	- 1	/							TOTAL TELES	
ditions.	b. 6	great	cancu	1							_	charc	
Sequentially list conditions, it any, beauting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.									Charic .				
ast	Due to (or as a consequ	uence of):								+		
	d											7	
pregnant months?	1 ☐ Live bi	come of pregnar irth 2 Tetal ant at time of de own	death 3	Ectopic pred Other (spec						23d. Date Mont		ery Day Year	
cant conditions o	ontributing to de	ath but not resu	ulting in the u	nderlying cau	ıse give	n in Part	l.	23e. Did	tobacco	use contrib	oute to t	he cause of death?	
								1 🗆	Yes 2	□No 3	Pro	bably 4 Honknow	
									ormed?	pri de	or to co ath?	opsy findings availab	
ed to medical						on Plac	e of Deat	1 ☐ Yes		11	_ Yes	2 No	
No.	Hospital:	npatient 2 🗆 E	ER/Outpatier	nt 3 DOA	Othe			me 5 Res		6 □Other	(Sneci	fv1	
5 Pending investigation	28a. Date of (Monti		28b. Time of Injury		c. Injury Work			28d. Describe				77	
6 Could not be determined		of Injury - At hong, etc. (Specify	me, farm, str					28f. Location City or To			or Aur	al Route Number,	
1 Certifying Ph 2 Medical Exan	niner: On the ba	asis of examinati	wledge, deatl	n occurred at vestigation, in	the tim	ne, date a pinion, de	nd place, ath occur	and due to the	cause(s)	and man	ner as s	stated. o the cause(s)	
title of certifier	and mann	ier stated.		290	License	number			29d. Da	te signed	(Month	Day, Year)	
5. 5011/101	WW.						3			1		3	
of a	, ,	o of death (to	02a\ /T :=:				_						
	TA MA	SUL SUL	W . I. /	54,	·	Ja se	rsto	eva, n	1D :	217	40)	
	005 32.	egistrar's Signat	ture	1 .1 .		-							
	AT DAT	ass of person who completed causes of person who completed causes of DATTA MICHAEL CONTRACTOR OF THE C	ess of person who completed cause of death (Item 1 DATTA MD 340 1 DATTA MD 340 2005 32. Régistrar's Signa	ass of person who completed cause of death (Item 23a) (Type, ATTA MD 340 W.L.) TOTAL YOR'S 2005 32. Segistrar's Signature	''	, ,	, ,	ess of person who completed cause of death (Item 23a) (Type, Print) ATTA MD 340 M.LC St. Ha gerst a MIDEN YOR'S 2005 32. Begistrar's Signature Jackson J. Jackson	,			ess of person who completed cause of death (Item 23a) (Type, Print) ATTA MD 340 WILL St. Hagerstown, MD Z1740	

		4	State of Maryland / Department of Health and Me		4005	1961.7
			negistrei	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia		LELA DRUMMOND		Day Yeer	6:07 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	L
	LXamiii	c.	HARTIEN HALL NURSING HOME POCOMOKE		WORCES	TER
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign try)
	Director		2/9-14-3786 1 M 24 9/ Yrs.	4-20-	14	VH
	land ow		10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
	Many e-f sh	to	MD WORCESTER POCOMOKE			1987 es 2 □ No
	or 28)Ire	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Coun	try?
	death with the Maryland ims 23e or 28e-f show r must be ricitified at	ral	SOS CEDAR ST. 21851	aity Voc or No	14. Race - Americ	an Indian
	ter de Itams	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spec	lican, etc.)	Black, White,	
936	hours after tural', or Ita	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼No II Yes 2 ▼No Specify:		Specify: B	LACK
21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or ltams 23e or 28e-f show evant, the Mariscal Evant retribute to rediffed at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	g 168	o. Kind of Business/Inc	dustry
21	within ene. than "	mple	Flementary/Secondary (0-12) College (1-4or 5+)		HOMEM	nkrp
	e filed v Il Hygie other t vant, In	S	5 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Mai		AKER
lan		To Be	GEORGE A CRIPPEN LEAH	CRI	POEN	
Maryland	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)	Route Number, C.	ity or Town, State, Zip	Code)
	and 2 ealth a m 27 is			comotie,	MD 2185	
ore	a o		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Commentary crematory or other place)	200	c. Location - City or To	own, State
Baltimore			· 4 Donation 5 DOther (Specify) JERUSALEM CHIECH 6 5	NNIES	MENANCE	VILLE, VA
Ba	permit. Pa Departmer Important any injury		21. Signature of Funeral Service Licensee	WALE W	D 218:51	
		\vdash	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician :		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cororary Artery Disease			Onset and Death
	/Medical		resulting in death) a. OICONARY RILL CTOY UISE A SE Due to (or as a consequence of):			
	Examiner		Sequentially list conditions.			
	e sit	iner	Sequentially list conditions, if any, leading to immediate cause. Each Underlying Cause (Disease or injury			
	xecuti and al-tran	Examine	resulting in death) Last Due to (or as a consequence of):			
8760	cate be executed obysician and the burial-transit		d			
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ledical			180 11 11 11 11 11	-
Box	eath certific attending pl	Physiclan/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1		23d. Date of delive Month	Day Year
	ie dea the at hed fo	/sicl	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown			,
P.0	that the de led by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	ne cause of death?
Records,	uires tha signed I Id be det	d by		1 □ Yes	2 No 3 Prob	ably 4 Unknown
00	w require been si should l	Completed		24a. Was an	24b. Were auto	psy findings available mpletion of cause of
	0 - 0	omp		autopsy performe	d? death?	2 No
ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical axaminer?			
of Vital	Physician: this certificant	10 1	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Hon		ce 6 □Other (Specia	ý)
o u	ding P	on:	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
Division	Attanding ir death. actor: After by the fune	licat	2 Accident		et and Number or Run	al Route Number,
DΪ	after Dirac	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	State)	
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director,	alc	29a. Certifier (Check only (Ch	and due to the caus	se(s) and manner as s	tated.
	the Ho	ledical	one) and manner stated.		I. Date signed (Month,	
	To To I	Σ	29b. Signature and title of certifier 29c. License number 0 0062172		05/25/20	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-100/00	
			SHARAD R SATYAL, MD 1604 MARKET ST. POLOMOKE (CITY MO	21851	
	St	ate	31. Date filed (Month Day, Year) 7 2005 32. Egistrar's Signature MAY 2 7 2005			
	Regist	trar	MICH WELDES Steller St. Spark			

		1	For State Registrar	State of Ma	iryland		artmen rtificat			and M		giene Reg. No.	110	9648
	Physici /Medic	an al	1. Decedent's Name (First, Middle, Lasi HGEN M. DOC 4a. Fecility Name (If not institution, give	glass			4b. Citv₄	Town, or	Location o	of Death	2. Date of Dea	Day 2	Year 2 05 County of Deat	3. Time of Death 19:30 PM
	Examin Funeral Director	CI	Chester River 5. Social Security Number 6. Se	Hospital	Ce (In yrs. la 98	ntck ast birthday) Yrs.	If Under Months	cste	/	DIL	8. Date of Birt (Month, Da 12/11/1	<u> 1</u>	Kent 9. Birtl	nplace (State or Foreign untry) York
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Kent			Town or Lo								10d. Inside City Limits 1 X Yes 2 □ No
	within 72 hours after death with the Maryland ane. than "natural", or Itama 23a or 28a-f show ita Marical Examilia a unat be notified a	Funeral Director	10e. Street and Number 303 Campus Avenue 11. Marital Status	12. Was Decedent 8	Ever in U.S	5. 13. 1	Was Deced	620 lent of Hi	spanic Ori	gin? (Spe	cify Yes or No	USA	14. Race - Ame	rican Indian,
9000	hours after o tural', or Itan	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 In Yes, Give Year or Dates:	10		1 🗆 Yes	2[X No	Specify:		Rican, etc.)	16b Ki	Specify: White	ite
21215-0036	77 70 10 10	Completed	(Specify only highest grad		+)	(Give life.	kind of wo DO NOT us nistr	rk done d se retired	during mos		ng (First, Middle,		Telepho Company	one
Maryland	ed its b	To Be	17. Father's Name (First, Middle, Last) Richard Brereton 19a. Informant's Name/Relationship (7	ype, Print)			-		Fran	ices er or Rura	R'adiga	a. er, City o	or Town, State, Z	"ip Code)
Baltimore, M	s 1 and if Health itsm 27 other tr	ļ ļ	John D. Brereton/ 20a. Method of Disposition 1 Burial 2 Termation 3 4 Donation 5 Other (Specify	Removal from State	CE	lace of Dispo emetery, crea NOT	osition (Nar matory or o	ne of ther plac	е)	D	ate	20c. Lo	D 21620	
Baltir	permit. Page Department of Important: If any injury or ance.		22. Name and Address of Facility Robert E. Evans Fun 16000 Annapolis Road Bowie, MD 2071 3a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											al Home
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	the death he. 2 CC a consequ	Jence of):	ter the mod	e or ayın	g, such as		respiratory at		2	Approximate Interval Between Onset and Death
,09,	Examiner and purial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as			Ac	3						
.O. Box 68760,	death certificate e attending phy od for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	⊒Ectopic p ⊒ Other (sp						23d. Date of del Month	very Day Year
Records, P.	The law requires that the ate has been signed by the page 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	inderlying o	ause giv	en in Part I		23e. Did t		- 6	the cause of death? obably 4 Tunknown
tal Rec	sician: The law r certificate has be irector, page 2 sh	• Completed	25. Was case referred to medical						26 Place	of Death	24a. Was autop perfo	psy ormed? 2€No	prior to death?	topsy findings available completion of cause of
ion of Vital	ding Phy n. After this funeral d	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ry	ER/Outpatie 28b. Time o Injury	_	8c. Injun Wor	er: 4 🗆 Nu	ursing Hor		dence	6 □Other (Spec ry occurred	sify)
Division	⊒ affe o	il Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et ysician: To the best	c. (Specify	/) 			ne. date ar		City or To	wn, State	e) 	ral Route Number,
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical		niner: On the basis o and manner sta	f examinar ated.	tion and/or in	vestigation	, in my o				date and 29d. Da	d place, and due te signed (Monti	to the cause(s) h. Day, Year)
•			30. Name and ad less of a rson who Semra Sahinci, M	completed cause of c				D61		, MD	21620	> `	23.0)
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Raistr			Carl	ر						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State	of Mary	land / Dep	artmen			and M		20		10010
	-		Registrar Decedent's Name (First, Middle)	e, Last)			- Incate	GOIL	Jean		2. Date of Dea		UU	3. Time of Death
П	Physicia /Medic		Valerie R	. Davis							Month	2 200	Year	0640 M
	Examin		4a. Facility Name (If not institution	_			4b. City,		Location o				y of Death	
			3035 Sun. 5. Social Security Number	5ct Lan		yrs. last birthda) If Under		If Under		8 Date of Birt	h Prin	a Righ	George's
	Funeral Director		579-78-9875	1 ☐ M 2 💢 F		47 Yrs.	Months	Days	Hours	Min.	8. Date of Birti (Month, Day Mar • 1	Year 1958	Wa	place (State or Foreign ntry) ISh., DC
	D		Usual Residence of Decedent		10.	c. City, Town or I								
	faryla shov	5	10a. State 10b. County Maryland Prince	o Coorgo		. City, TOWITOF		itla	nd					10d. Inside City Limits 1 √Yes 2 No
	the N 28e-1 notifi	Director	10e. Street and Number	e George			10f. Zip					10g. Citizen of	What Cou	ntry?
	tiled within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23s or 28e-f show uth, the Medical Examinar must be notified at	al DI	3035 Suns	et Lane					2074	46		Un	ited	States
	r deat	ner	11. Marital Status	Armed	ecedent Ever Forces?	in U.S. 13	. Was Deced	lent of Hi	spanic Ori n, Mexican	gin? (Spe	cify Yes or No- Rican, etc.)	14. Ra Bla	ce - Ameri ack, White,	
36	rs afte	by Fi	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes.	s 2 No Give X Dates:		1 ☐ Yes	≥ №	Specify:			Speci	^{ty:} B1	ack
21215-0036	2 hou latura	Completed by Funeral	15. Deceder	t's Education		16a. Dec	edent's Usua e kind of wo	al Occupa	ation	t of worki	00	16b. Kind of E	Business/Ir	ndustry
215	ithin 7 ne. nen "n	nple	(Specify only higher Elementary/Secondary (0-12) 12th		(1-4or 5+)		DO NOT us	se retirea)	(Or WORK)	ng	n	rivat	-
	iled w lygier ther th	Col	17. Father's Name (First, Middle,	Last)			п	omen	aker	er's Name	(First, Middle,			.e
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or othar traumatic avant, the Medical Examiner must be notified at once.	To Be	James Da									a John		
ary	shou and M s mar	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Ma	ling Address	(Street a	and Numbe	er or Rura	I Route Numbe	r, City or Towr	n, State, Zip	Code)
	and 2 ealth m 27 I		Tameral L. D	avis-Dau		3. 0b. Place of Dis			St.,		2. #101 Date			20032
Baltimore,	nt of H if Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		m State	cemetery, cr	ematory or o	ther plac	. 1		1	20c. Location		
III	artmer ortant injury		* 4 □ Doration 5 □ Other (S		0	Harmony	Memor 22. Name an				./2005_ :ewart			
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			23a. Part1. Enter the disease, o shock, or heart failure. List	complications the	at caused the n each line.	death. Do not e			_					Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due	to (or as a co	nsequence of):								
į,	4993	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or ir ju.)	b. Due	to (or as a co	nsequence of):								
	icuted nd transit	Examiner	that initiated events	С										
,092	ate be executed hysician and he burial-transit		resulting in death) Last	Due	to (or as a co	nsequence of):								
687	ficate physics the l	edical		d.							-			
Box (death certificat e attending phy id for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pre		□Ectopic pr	ennancy					ate of deliv	
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre	egnant at time		Other (sp					M	onth	Day Year
P.0	requires that the leen signed by th hould be detache	Phy	Part II. Other significant conditi	ons contributing to	o death but no	ot resulting in the	underlying c	ause give	en in Part I.		23e. Did to	bacco use cor	ntribute to t	he cause of death?
rds,	es pe	d by									1 🗆 Y	′es 2□No	3 🗌 Prol	bably 4 Onknown
Record	> 40	Completed									24a. Was		Were auto	opsy findings available ompletion of cause of
Ä	The ate h page	Com									perfo	rmed? 24 No	death?	2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe	or		(Check only o			
of	ding Phys h. After this funeral dii	To To	1 Yes 2 No 27. Manne of Death	28a. Da	te of Injury	2 ER/Outpati		8c. Injun Worl	4 140		me 5 Resid 28d. Describe h			fy)
ion	Attanding ir death. ector: After by the fune	atio	E _ / tooldont	gation	lonth, Day Ye	ar) Injury	М		Yes 2 🗆	No				
Division	l or Attano after deatl Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Pla	ace of Injury - ilding, etc. (S	At home, farm, pecify)	street, factory	, office			28f. Location (S City or Tow		ber or Rur	al Route Number,
	Hospital 24 hours a Funeral E	al Ce	29a, Certifier 1 ☐ Certifyi	ng Physician: To	the best of m	v knowledge, de	ath occurred	at the tin	ne, date an	nd place,	and due to the	cause(s) and m	nanner as s	stated.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only 2 Medical one)	Examiner: On the and m	e basis of exa anner stated.	mination and/or	investigation	, in my o	pinion, dea	th occurr	ed at the time,	date and place	, and due t	o the cause(s)
	To the h within 24 To the f complete	Σ	29b. Signature and title of certific	or (1/	+	-	290		a number			29d. Date sign	ed (Month,	Day, Year)
^			30. Name and address of person	N /4/	-3/2	D0	a Drint)	1400	053	771	7	MAY	23	1005
K	(3)		SA(VAdo. Su)	vester	3001	Ites DIT	al I	011-	e, C	لما	why 1	IAry /	and	
	Sta		31. Date filed (Month, Day, Year	3	Registrar's	Signature	م.				1			
	Regist	rar	MAY 3 1	ZUUD	in the	N A	W.							

			For State Registrar	State of Mary			lealth an		_	05	196	550
	Dh!-:		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Үөөг	3. Time of	Death
	Physici /Medic			cholas C. D	ilenno,			June_		005	1815	P ^M
	Examin	er	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or		Death	4c. County			
	5		Annecy Hall 5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	Childs If Under 1 Year	If Under 24	Hrs. 8. Date of Birt	Cec		lace (State or	r Foreian
Н	Funeral Director			[M 2□F 92	Yrs.	Months Days	Hours	Hrs. 8. Date of Birtl (Month, Day July 12	2, Year) 2, 1912	De1	lace (State or try) .aware	
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside Cit	y Limits
	Manyl f sho	lor	Maryland Cecil		Childs						1 ☐ Yes	2 1 No
	r 28a	Director	10e. Street and Number			10f. Zip Code	,		10g. Citizen of	What Cour	itry?	
	th with	al D	1120 Blue Ball Ro	oad		21916			Unite	d Sta	ites	
	r dea	Funeral		2. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin an, Mexican, F	? (Specify Yes or No- querto Rican, etc.)	14. Rad Blad	e - Americ ck, White,		
36	thin 72 hours after death with the Maryland e. an "netural", or Itams 23a or 28e-f show Macinal Examiner must be notified at	by Fi	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Specif	v: Wh	ite	
21215-0036	72 hou netura	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	ation	fadia	16b. Kind of B			
215	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	1)					
121	73 '50 -		17. Father's Name (First, Middle, Last)	5+	Pries	t/Constru		Engineer Name (First, Middle,	Religi			
Maryland	0 to 0	Be C	Nicola Dilenno					la DiLucia		10)		
IZ.	d 2 should th and Mer 7 is marks traumetic	ဥ	19a. Informant's Name/Relationship (Type	ов, Print)	19b. Maili	ng Address (Street a		or Rural Route Numbe		State, Zip	Code)	
	and 2		Oblates of St. Fran					y, Wilming	ton, De	lawa:	re 1980	06
Baltimore,	of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	:e) J	une 7,	20c. Location -	City or To	wn, State	
ij	nit. Pages bartment of l cortant: If ite injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)			Cemetery	2	005	Childs			
Balt	permit. Page Department of Important: If any injury of		21. Signature of Funeral Service License). A -	, H	2. Name and Addres ICKS Home	ss of Facility For F	unerals, P Street, El	.A.			
ì	46244		23a. Part1. Enter the disease, or compli	cations that caused the						aryla	Approximate)
	Prysician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			560				Onset and D	
	/Medical		disease or condition resulting in death)	Due to (or as a co	onsequence of):	ructive	pujin	WILL 011	ease		ing de	>
	Examiner		Sequentially list conditions	Coro	ning a	atery o	year			17.1	10 4	4
	be sit	lner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a so	onsequence of):	22	1/				F 0	
	sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a co	onsequence of):	2	opash	4			2 2	4 -
760,	te be executed ysician and te burial-transit	calE	d	· ·								
99					1332							
Вох	death certifics e attending ph d for use as th	an/N	23b. was decedent pregnant	3c. If yes, outcome of p 1□Live birth 2□		JEctopic pregnancy				te ol delive	,	
В	at the dea by the at tached fo	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐ Unknown	e of death 5[Other (specify)			IVIC	nth	Day Y	'ear
٥.	pe ee		Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of de	eath?
rds,	luires n signe	d by						1 □ Y	'es 2□No	3 Prob	ably 4 □U	nknown
Record	s been s shoul	Complete						24a. Was			osy findings a	
- Re	The tav ate has page 2	mo:						— autop perfor 1 ☐ Yes	med2	death?	npletion of ca 2□ No	use o
Vital	icien: T certificat rector, pa	Be	25. Was case referred to medical examiner?					Death (Check only o				
of	Phys this al dii	To.	1 ☐ Yes 2 ☑ No ☐ ☐ 27. Manner of Death	ospital:		t 3 DOA Othe	er: 4 ☐ Nursi	ng Home 5 sesio			")	
O	ther ne	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	nar) Injury	Worl	k?" Yes 2 □ No		iow injury cocur			
Division	sal or Attending s after death. sl Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st.	reet, lactory, office		28f. Location (S City or Tow		er or Rura	l Ro⊔te Numb)0 <i>r</i> ,
ā	7 7 7 6	Cert	4 Torricas	building, etc. (3	specify)			Ony or row	,, State)			
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	ne, date and p pinion, death	place, and due to the o occurred at the time, o	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License			29d. Date signe			_
				3.7		C2-	-0005	526	June	3,	2005	
_	10		30. Name and address of person who co	. Horah	, D.O.	Print)	ubuh	526 Puzz	. New	uh I	NE 197	14
	Sta Regist		31. Date filed (Month, Day, Year) 20	05 32 Registrar's	Signatus							

Loren K. Dean 05-03846 MLO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

			1. Decedent's Name (First, Middle, L	State of Maryland / &4a-b&Unpend Item i I per me G844 6- .ast)	20-eouncale of Dealifo-14	2. Date of Death		3. Time of Death
	Physici		Loren Kenneth De Lorne Kenneth De		an	June 5,	2005 Year	10:40a м
	/Medic Examin	or	4a. Facility Name (If not institution, g	rive street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		•	10 Joseph Callh 27 Walnut St. 5. Social Security Number 6.	er Street	Tilkton North Fast If Under 1 Year If Under 24 Hrs. Months Davs Hours Min.		Cecil	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last be	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthpl	ace (State or Foreign
	Director		215 04 5362	1XDM 2□F 36	Yrs. World's Days Hours Will.	June 18.		
	pu ,		Usual Residence of Decedent	100 City To	vn or Location		-	Od. Inside City Limits
	aryla shov	-	10a. State 10b. County	Toc. City, Tov	WIT OF LOCATION		"	1 ☐ Yes 2 🕅 No
	88 -1 M	Director	Maryland Cecil	E1ktor				
	vith ti	Dir	10e. Street and Number		10f. Zip Code	109	Citizen of What Coun	try?
	ath v	rai	10 Joseph Gallah		21921		nited State	
	er de Items	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	14. Race - Americ Black, White, e	
36	rs aft		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-1 show ha Madisal Examinat musi be notified at	Completed by	15. Decedent's		a. Decedent's Usual Occupation	16	b. Kind of Business/Inc	ustry
15	in 72 n "ns Aedis	piet	(Specify only highest of	grade completed)	(Give kind of work done during most of worki life. DO NOT use retired)	ng		,
72	l withir liene. r than the Ms	mo	Elementary/Secondary (0-12)	Callege (1-4or 5+)	Concrete Finisher	c	oncrete	
	be filed within 72 hc tal Hygiene. d other than "natur event, the Medical	a	17. Father's Name (First, Middle, La.	st)	18. Mother's Name	(First, Middle, Ma	den Sumame)	
Maryland		To B	Thomas Kenneth D	ean	Eunice St	yles		
ary	2 should and Men is marke eumetic	Γ,	19a. Informant's Name/Relationship	(Type, Print) 19	b. Mailing Address (Street and Number or Rura	al Route Number, C	ity or Town, State, Zip	Code)
	5 5 E 5		Donnita M. Dean/	Daughter 48	37 Mechanics Valley Ro	ad North	East, Mary	land 21901
Ē,	of Heal		20a. Method of Disposition	20b. Place of	of Disposition (Name of Early, crematory or other place)	Date 20	c. Location - City or To	wn, State
Ę			1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Society)	Pemoval from State North	East Methodist June Cemetery	9,2005No	rth East,Ma	aryland
Baltimore,	artn orte inju		21. Signature Fundal Secrete Lic	500	00 11 1011 15 17	couch Fun	eral Home	
ä	Dep Imp		11111	2	127 South Main Stre			Land 21901
	-		23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused the death. Do	nol enter the mode of dying, such as cardiac of			Approximate Interval Between
	Physician	6 0	Immediate Cause (Final		lochel interioriestion			Onset and Death
	/Medical		disease or condition resulting in death)	a. Methadone and a Due to (or as a consequence	lcohol intoxication			
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oʻ	en ar		resulting in death) Last	Due to (or as a consequence	n			
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68	E G		IC CEMALS.	d	of):		1.12	
	th certii lending r use a		IF FEMALE: 23b. Was decedent pregnant	d			23d. Date of delive	-
. Box	death certificat ne attending phy ed for use as the		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death				ry Day Year
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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No. 2005											
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth Month Dey Year 3. Time of Death											
/Medical	Helen Elizabeth Eichelberger	May 27, 2005 10:10 P.M.											
Examiner	4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Deeth 4c. County of Death											
	Williamsport Nursing Home Williams	port Washington											
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1	8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Country)											
Director	213-18-8898	Sept.2,1922 Delaware											
pu ≱	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits											
the Maryler 28e-f show notified at		XYes 2 □ No											
the N	Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?											
with page 10													
eath re 23	203 Otho Holland Drive 21795 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spr	USA ecity Yes or No- 14. Race - American Indian,											
d 21215-0020 filed within 72 hours efter death with the Marylend Hygiene. ther than 'natural', or items 23a or 28a-f show out, the Medical Examiner must be notified at a Completed by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.											
002(ours e	3 Widowed 4 LJ Divorced Year or Dates:	Specify: White											
72 h 72 h and a second alicent	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) If a. DO NOT use retired)	16b. Kind of Business/Industry											
1 21215-00 ed within 72 hou vigene. Per than "natura nt tra nt, the Medical Ent.	Elementery/Secondary (0-12) College (1-4or 5+)												
Cor Cor	Sewing Machine Operator												
Baltimore, Maryland 21215-0020 semit. Peges 1 end 2 should be filed within 72 hours ett bepartment of Health and Mentel hygiene. mportant: if item 27 is marked other than "natural", or my injury or other traumatic event, the Medical Examples. To Be Completed by F		e (First, Middle, Maiden Surname)											
arylanc		h Helen Campbell											
Mar 12 sho 18 me 18 me	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rure												
s 1 end 2 s 1 tend 2 s	Doris V. Zimmerman - Sis. in law 15314 Falling Waters 20a. Method of Disposition (Name of	Rd. Williamsport MD 21795 Date 20c. Location - City or Town, State											
Baltimore, pemit. Peges 1 en Department of Heal Important: if item 2 any injury or other once.	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State												
timent: Pertaint:	4 Donation 'S Other (Specify) Smithsburg Crematory 5-	-30-05 Smithsburg,Maryland											
Ball eermil Separ mpor mpor mpor mpor	21. Signature of Funeral Service 10:000 22. Name and Address of Facility Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795												
0		•											
57	23a Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or hear failure. List only one cause on each line.	or respiratory arrest, Approximate Interval Between											
Physician	Investigation Court (That	Onset and Death											
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) e. Chronic Obstructive Lung D	isease years											
C-village in the	Due to (or as a consequence of):												
68760, ficate be executed physician enter its the buriel-transit edical Examiner	b												
68760, tificate be executed or physician enter es the buriel-transit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury												
760 760 9 be e													
68760, filtrate be expression as the burier edical E	resulting in death) Last Due to (or as a consequence of):												
Box (Box out) bath certification of the certificati	d	1											
Beath Beath death defor	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?											
O: the ache	,	1 Nee 2□ No 3□ Probably 4□ Unknown											
S, P	Osteoporosis	19.00 22.00 02.000.											
Helen Class P.O. Box 68760 , Attending Physician: The law requires that the death certificate be executed releath. Attending Physician: The law requires that the death certificate be executed releath. by the tuneral director, page 2 should be detached for use as the buriel-trinsit filtration: To Be Completed by Physician Medical Examir		24a. Was en autopsy performed? 24b. Were autopsy findings available prior to											
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Division of Vital Records, for Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed by	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)											
Cer Safe Ci													
Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred												
thin 2 the formplet	one) end manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)											
or with		May 28, 2005											
	Cynthia Kuttner-Sand, mp D47451												
	30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Nursing Home, Cynthia Kuther-Sands MD Williamsport Williamspo	154 North Artizan Street											
5H-2	31. Date filed (Month, Pay, Year) 32. Registrar's Signature	rt, Maryland 21795											
State Registrar	31. Date filed (Month, Pay, Year) 1 2005 32. Registrar's Signature												
i regiotiai													

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Day Month Year **Physician** Mary Lena Frush /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washinatan lagerstown Washington County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4/14/1903 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F 102 Director 578**-**09-9252 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number with 416 W. Wilson Boulevard 21.740 United States or Items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status o filed within 72 hours after do I Hygiene. other than "naturel", or Item other treumatic event, the Medical Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White à 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) News/Media Secretary Pages 1 and 2 should be filed vent of Health and Mental Hygies int; if Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Wellinger Mary Elizabeth Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanette Wolford/niece Falling Waters, West Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) injury or permit. Page Department of Important: If any injury or Rose Hill Cemetery 6/3/05 Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home Stratus of Funeral Service Licensee 305 N. Potomac St., Hagerstown, MD 21740 23a. Part1 Inter the disease, of complications that cause the disease, or heart failure. List only one cause on each ing Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or high that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physiclan/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown licant conditions contributing to death but $\sqrt{\delta}$ t resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to med examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L To the Hospitel 29a. Certifies 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31, Date filed (Month

5H-12

32. Registrar's Signature

			Please		Indelible Ink. Ensure A partment of Health and N	•		
		•	1 - State Registrar	_	Sertificate of Death		Reg. No. 2005	10651
	Physici	an	1. Decedent's Name (First, Middle, Las			2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al		Alberta Sarah Frey	4h Chu Taura and a shared Dank	June	5 2005	1400 P M
	Examin	er	4a. Facility Name (If not institution, give 403 Park Place	street and number)	4b. City, Town, or Location of Death Elkton		4c. County of Deat Cecil	n
\mathbf{I}	Funeral	_	5. Social Security Number 6. Se		ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birtl	h 9. Birt	nplace (State or Foreign
	Director		177-05-6518	□ M 2 X F 87 Yrs	Months Days Hours Min.	May 6,	1918 Mid	chigan
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	with the Maryland a or 28a-f show be nelliged at	tor	Maryland Cecil	E1ktor	1			1∭XYes 2☐No
	th the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
	ath wi		403 Park Place		21921		United St	
	ltems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	urs af	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Wh	ite
2-0	72 ho 'netur	eted	15. Decedent's Ed (Specify only highest gra	de completed) (G	ecedent's Usual Occupation live kind of work done during most of work	king	16b. Kind of Business/	ndustry
Maryland 21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "neturel", or Items 23a or 28a-f show event, tre Mcdicel Examirer must be mailled at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired) Iomemaker		In Her Own	Ното
d 2	filed Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)	,		e (First, Middle,	Maiden Sumame)	1 Home
/an	Aental Aental rked tic sv	To B	Frederick Charle	es Tretheway	Caroli	ne Morga	ın	
lan	2 should I and Meni Is marked		19a. Informant's Name/Relationship (7		ailing Address (Street and Number or Ru		_	
	1 and tealth sm 27 ther tr		Cary L. Frey, S1		201 St. Johnsbury Lassosition (Name of	ane, Ger	mantown, MI	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a any injury or other traumatic event, Ire Medical Examinator matter.		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			e 8,		
菲	nut. P part ne cort-in injury		21. Signature of Funeral Service Licen	_ IICMOT IC	al Park 200. 22. Name and Address of Facility Hicks Home for Fune		Elkton, Mai	yrand
, m	permit. Depart Import any inj		1 David	S. Hicks	Hicks Home for Fune 103 W. Stockton Str	eet, Ell	.A. kton, Maryl	and 21921
n			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	. Deliga	Ration			14 west
	/Medical Examiner			Due to (or as a consequence of):	Harlot de la	mol	one	112 +11.1
	* 1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (of as a consequence of).	i location.	1		Hamaria
V	ocuted nd transit	amin	that initiated events	c				
90,	cate be exec physician ar the burial-ti	al Ex	resulting in death) Last	Due to (or as a consequence of):				
68760,	icate be ex physician s the buria	dica		d				
Box (leath certific attending pl	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of deli	,
	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		5 Other (specify)		Month	Day Year
P.O.	res that the de signed by the a l be detached f	Phy	9 Unknown	ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	uires l signe Id be		•	,	, , , , , , , , , , , , , , , , , , , ,	1 🗆 Y		bably 4 🗀 Unknown
cor	w requir s been si should	Completed				24a. Was a	an 24b. Were au	topsy findings available
Re	The lav	omo				autop: perfor	med? death?	ompletion of cause of
/ital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Dea			
	Physic this of	10	1 □ Yes 2 🖟 10	Hospital: 1 Inpatient 2 ER/Outpa			ence 6 Other (Spec	ufy)
-	Attending Physicien: The law requires that the death certificate be exercideath. sector: After this certificate has been signed by the attending physician are the funeral director, page 2 should be detached for use as the bunat-	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju		200. 2000100 ()	ow injury occurred	
9	death. ctor: A the fu	ca	3 ☐ Suicide 6 ☐ Could not be		, street, factory, office		treet and Number or Ru	ral Route Number.
visior	P d d	三		hulding ata (Caralta)				
Division of	tel or Att rs after d el Direct ed in by	Certification:	4 Homicide determined	building, etc. (Specify)		City or Tow	n, State)	
Division	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Certifi	4 Homicide determined 29a. Certifier 1 Certifying Ph	building, etc. (Specify) ysician: To the best of my knowledge, d	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the c	cause(s) and manner as	stated.

State Registrar 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATELMI 123

31. Date filed (Month, Day, Year)

32 Registrar's Signary

			For State Registrar	State of I	Maryland	/ Depa	artment of I	lealth and Death	d Mental Hy	/giené Reg. No		19655
			Decedent's Name (First, Middle	, Last)					2. Date of D	eath		3. Time of Death
	Physicia		Marion Lynn G1	266					Month	Day 2.5	y Year 2005	10:30A. M
	/Medic Examin		4a. Facility Name (If not institution		er)		4b. City, Town, o	or Location of De			. County of Death	
	LAGITITI	-1	12820 EPPING TE	DD A C F			STLVE	R SPRIN	G	MC	NTGOMERY	7
	Funeral		5. Social Security Number		Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 H	irs. 8 Date of Bi	rth		place (State or Foreign
	Director		217-44-9485	1□M 2 X F	60	Yrs.	Months Days	Hours M	in. (Month, D) 02/24/	1945		ington, DC
	p		Usual Residence of Decedent									
	show	_	10a. State 10b. County			Town or Lo	cation					10d. Inside City Limits
	Be-f	Director	MD Montgo	mery	Whea	Lon						1 X Yes 2 No
	or 24	Sire	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	intry?
	23a	a	12820 Epping Te				20906				ed State	
	r deg	Funerai	11. Marital Status	12. Was Decede Armed Force	es?	13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or N lerto Rican, etc.)	0-	 Race - Ameri Black, White 	
9	or i	by Fi	1 Never Married 2 Marr	If Yes, Give			1 ☐ Yes 2 📉 No	Specify:			Specify: Wh	ite
Ö	houn turei	d b	3 ☑ Widowed 4 ☐ Divorced 15. Decedent	Year or Date		160 Dogge	dent's Usual Occu	nation		16h V	ind of Business/Ir	- duatas
<u> </u>	"nai	Completed	(Specify only highes	it grade completed)		(Give	kind of work done DO NOT use retire	during most of a	working	100. K	ing or businessyr	ndustry
12	withi ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4			tive Dir	,		Syn	agogue	
2 2	filed Hygi ther		17. Father's Name (First, Middle,	<u></u>		LACCU	CIVC DII	Y	Name (First, Middle			
Maryland 21215-0036	d be antal ced o	o Be	Bernard Mosner					Louise	Miller			
7	shoul od Me mark	٦	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street		Rural Route Numb	per, City o	or Town, State, Zi	p Code)
$\mathbf{\Xi}$	ith ar 27 is r treu		Leslie Altschul	er - Siste	r	15/12	Ritterr	oot Waw	Rockvill	о M	m 20053	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "naturel; or iteme 23s or 28e-f show may injury or other treumetic event, it a Medical Examination master invitible at once.		20a. Method of Disposition	CI SISCE	20b. Plac	ce of Dispo	sition (Name of		Date		ocation - City or T	own, State
2 D	Se in so		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		316		natory or other pla		/27/2005	01	MD	
≟	permil. Pag Department importent: any injury once.		21. Signature of Funeral Service		Jude		. Name and Addre		/27/2005	OIN	ey, MD	
Ba	Dep imp		Pr sont	- a Cal	in IT	- Hi	nes-Rina	ldi Fund	eral Home	, In	c	2000/
			23a. Part1. Enter the disease, or	complications that cau	sed the death.	Do not ent	800 New er the mode of dvi	Hampshi: no. such as card	re Ave Si	Lver	Spring	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.			-				Interval Between Onset and Death
	Pny sicia n /Medical		disease or condition resulting in death)	a	aaaa	a N	eckIv	ywie.	2			
	Examiner			Due to (or	as a conseque	nce or):						
		ā	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a conseque	nce of):					-	
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(
	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or	as a conseque	nce of):						
8760,	cate be executed physicien and the burial-transit	dicai I										
68	ficate g phy is the	edic		U								
Вох	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Date of deliv	rery
m	atte for	cial	in the past 12 months?		h 2 ☐ Fetal de nt at time of dear]Ectopic pregnand] Other (s <i>pecify</i>) _	У			Month	Day Year
o.	that the de ed by the detached	Jys	9 Dunknown	9□ Unknow	n							
<u>.</u>		by PI	Part II. Other significant condition	ons contributing to deal	th but not resulti	ing in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco L	use contribute to t	the cause of death?
Vital Records,	requires sen sign hould be	q p	Intracevenell	ar Hemo	Whage	2			1 🗆	Yes 2	No 3□Pro	bably 4 \(Unknown
000	w requir been si should	Completed			/				24a. Was	an	24b. Were auto	opsy findings available
Re	The law ate has b page 2 s	ш							auto	ormed?	death?	impletion of cause of
a		e Cc	25. Was case referred to medical			-		OF Place of F	1 Thes Death (Check only	2 No	1 XYes	2 □ No
⋚	Physician: this certific ral director.	OB	examiner?	Hospital:	atient 2 EF	2/Outpation	. 3FT DOA ON		g Home 5 Res		6 (VOther /Speci	AV COTTO
of		\vdash	27. Manner of Death	28a Date of	Injury 2	8b. Time of	28c. Inju	ry at	28d. Describe			on SCHIVE
O	iding Ph th. : After th funeral	tioi	1 ☐ Natural 5 ☐ Pendin 2 💢 Accident investig		Day Year)	Four		rk?]Yes 2.02∭No	Sub	lect	fell	
Division of	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could i	not be		e, farm, str	eet, factory, office		28f Location	(Street an	d Number or Rur	al Route Number,
ă	after Dire	erti	4 Homicide		i, etc. (Specify)				City or To	wn, State	12820 E	pping Terrace
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the			g Physicien: To the b	est of my knowle	edge, death			ace, and due to the	cause(s)	and manner as s	
	s Fulletely	edical		Examiner: On the bas and manne	is of examination							
	Fo the within 2 Fo the comple	Me	29b. Signature and title of certifie	r			29c. Licen	se number		29d. Dat	te signed (Month,	Day, Year)
	,- > F 0		· Carch	Halla	am	d	OCI	ME	1	MAY 2	26, 2005	
	to		30. Name and address of person			-	Print)					
	Q		CAPUL	H ATL	AWM	A		nn Stree	et Balti	more	, Maryla	nd 21201
	Sta	te	31. Date filed (Month, Day Year)	A. Reg	istrar's Signatui	re /					· · · · · · · · · · · · · · · · · · ·	
	Registr		MAY 27	2005	gistrar's Signatur	SEC. SEC.	Section .					

			For State Registrar	State of Ma	aryland	•	artment o			nd Me		jiene leg. No.	200)5:	1965	The state of the s
			Decedent's Name (First, Middle, La	st)						2	. Date of Dea Month	th Day	Ye	.	3. Time of Death	
	.Physicia /Medic		Luc	ille Sharp	Gree	n				I	May	27	200		10:30 A M	
)	Examin		4a. Facility Name (If not institution, giv				4b. City, Tow	m, or L	ocation of [Death	_	4c.	County of D	eeth		
			Millennium of Ell						t Cit	4			Howa			
ľ	Funeral Director		5. Social Security Number 6. S 218 44 8341	ex 7. Ag □M 2 🗚 F	e (In yrs. I. 95	ast birthday) Yrs.	If Under 1 Y Months Da	ays	Hours	8.41-	Date of Birth Month Day Aug 9	1°90	9.	Birthpla Counti Mary	ice (State or Foreign Land	1
	pu ,	-	Usual Residence of Decedent 10a, State 10b, County		10c Cib	, Town or Lo	ecation							10	d. Inside City Limits	
	ahov	5												,,,	1 ☐ Yes 2 ZNo	
	the N	ect	MD Howard 10e. Street and Number		L'TT	i∞tt	10f. Zip Co	de				10α. Citiz	en of What	Count	n?	
	with Sa or		3004 N. Ridge Roa	nd				043				•	nited		•	
	death ma 2:	Funeral Director	11. Marital Status	12. Was Decedent		S. 13.	Was Decedent		panic Origin	n? (Speci	fy Yes or No-	1	4. Race - A			_
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural" or Itema 23e or 28e-f show importent: If Item 27 is marked other than "natural" or Itema 25e or 28e-f show any injury or other treumatic event, Ite Medical Examinar must be notified at ance.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			1 Yes, specify t 1 ☐ Yes 2 🔀		Specify:	Puerto Hi	can, etc.)		Black, W Specify: 1	/hite, e Whit		
P	2 hou	ed	15. Decedent's E	ducation	-		dent's Usual O					16b. Kir	nd of Busine			-
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Maryland 21215-0036	al Hy d oth	Be (17. Father's Name (First, Middle, Last)							First, Middle,	Maiden .	Sumame)			
<u>ya</u>	should be ind Mental marked o	2	Asa C. Sharp						Emma 1	-4						_
Jar	2 sh and is m		19a. Informant's Name/Relationship (-			ng Address (St									
	1 and Health am 27 ther tr		Ann Slaybaugh/Dat 20a. Method of Disposition	ighter	20b. P		Park G		e Ave	nue (-		e, MD		_	
סר	Pages nent of P ant: If its		1X Burial 2 ☐ Cremation 3 ☐		C	emetery, crei	natory or other Cemete	r place)		6-1-					le, MD	
Baltimore,	permit. Pa Departmen Importent any injury once.		4 □ Donation 5 □ Other (Speci. 21. Signature of Funeral Service Lice		M010										Ly FH Inc	
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100	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	ne.	eme	er the mode of		such as ca	ardiac or i	respiratory arr	rest,			Approximate Interval Between Onset and Death	
	Examiner			Due to (or as	a consequ	uence of):										
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	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										1		
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387	physi physi s the t	dicai		_ d							<u></u>					_
Box 6	ath certif attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	□Ectopic pregn					2	3d. Date of Month		y Day Year	
o.	that the do	ysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9☐ Unknown				,,								
<u>a</u>	ires that signed b d be deta	þ	Part II. Other significant conditions	contributing to death b	out not resu	alting in the u	nderlying caus	e given	in Part I.						cause of death?	_
Vital Records,	w requir been si should	Completed									24a. Was a	ลก	24b. Were	autop	sy findings available	,
Re	9 4 9	duc								_	autop: perfor	med?	prior deati	to com	pletion of cause of	
ta	ician: Th certificate rector. pag	Be C	25. Was case referred to medical						26. Place o	of Death (Check only o	210 No		185 4	204 110	-
	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 反 No	Hospital: 1 Inpatie	ent 2	ER/Outpatier	nt 3 DOA	Other	THE PARTY OF		5 ☐ Resid		Other (5	Specify,		
on of	Jing After fune		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time o Injury	f 28c.	Injury a Work?	at es 2 □ No		d. Describe h	ow injury	occurred			
Division	r At ter c irec irec n by	Certification:	3 Suicide 6 Could not to determined	De Blace of In	jury - At ho lc. (Specif)	ome, farm, st	reet, factory, of	fice		28	f. Location (S City or Tow		1 Number o	r Rural	Route Number,	
4	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical C		hysician: To the best miner: On the basis o and manner st	of examina											
	Fo the	Me	29b. Signature and title of certifier				29c. Li	cense	number		- 2	29d. Date	signed (M	onth, D	Pay, Year)	-
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			30. Name and address of person who	completed cause of	61 .	F 1	Print) RC	del	FOE	TE	RNAL		2,1	42	PA	_
			405 tredent	W VCd	17-C	107	. (311	2~7 \	114	1	<	-14	2	\$	
dr.	Sta Regist		31. Date filed (Month, Day, Year) MAY 3	32. Regist			A 46	p _								

DHMH 17 Rev 1/2001

ORIGINAL

			. For	State of Maryl		artment of H		•		gible.		
			1 - State Registrar		Ce	ertificate of	Death		Reg. No.	105	19	657
H	Physici	1÷	1. Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day	Year	3. Time o	f Death
	/Medic		Mary	V		Gossard		May	24,	2005	7:55	P M
	Examin	er	4a. Facility Name (If not institution, give si				r Location of Deatl	h		nty of Death		
			13818 Village Mill 5. Social Security Number 6. Sex		vrs. last birthday	Maugan // If Under 1 Year	SV111e If Under 24 Hrs.	8 Date of Bird		shing	ton place (State	or Foreign
	Funeral Director			M 25 F 67	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da June 20	7 (1937)	COU	ntry) Sylvar	_
	ס		Usual Residence of Decedent									
	anylar show	_	10a. State 10b. County		. City, Town or I ugansvi						10d. Inside C	City Limits 2 □ No
	Ne M	ecto	Maryland Washingto 10e. Street and Number	II FIE	ugansvi	10f. Zip Code			10= Citizen	-6 14/h -4 C		
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or tems 23a or 28a-f show ont. The Maclical Evant for must be mattilled at	Funerai Director	13818 Village Mill	Dr.		21767			U.S.A.	or winat Cou	intry?	
	ns 23	era		2. Was Decedent Ever	in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No		ace - Ameri		
9	or Ite	Ē	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give			Specify:	o Rican, etc.)		lack, White	, etc.	
003	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Spec	Whit		
15-("natu	Completed	15. Decedent's Educ (Specify only highest grade		(Giv	edent's Usual Occup re kind of work done DO NOT use retired	durina most of wor	rking	16b. Kind of	Business/Ir	ndustry	
12	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ewife	"/		Domes	tic		
d 2	i filed I Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden Sum	ame)		
<u>lan</u>	uld be Aenta rkad tic ev	To B	Elmer Franklin May	, Jr.			Baulah E	Ray New1:	in			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Maclical Event are must be indifficult any injury or other traumatic event, the Maclical Event are must be indifficult and once.		19a. Informant's Name/Relationship (Typ			iling Address (Street			-			
	and ealth m 27 her tr		Richard J. Gossard					Maugan:				
Baltimore,	ges 1 it of He if iter or oth		20a. Method of Disposition 1	moval nom State		position (Name of ematory or other place			20c, Locatio	•		
薑	it. Pa irtmer irtent njury		*4 □ Donation 5 □ Other (Specify) 21. Sign tup of Funeral Service Line se			ven Cemete	The second secon					
Ba	permit. Pages of Department of Importent: If ite any injury or of once.		21. Signify of Fulleral Service Company	~~-			own, MD	st Have				
			23a. Part1. Enter the disease, or complic	ations that caused the	death. Do not e					шта г	Approxima	te
	Pnysician		shock, or heart failure. List only one	e cause on each line.	2:	0 1100	7 Fr	a. O			Onset and	
4	/Medical		disease or condition resulting in death)	Due to (or as a cor	sequence of):	~ ITE	30111	www.				Jesus _
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1/	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequence of):							
ν_^	be executed sician and burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a cor	sequence of):							
760,	w	cai	d									
99	tificate og phys as the				31000					1325		
Вох	leath certificat attending phy I for use as th	an/h	23b. was decedent pregnant	Bc. If yes, outcome of pre 1 ☐ Live birth 2 ☐		☐Ectopic pregnancy	,			Date of deliv Month	*	Year
.O.	le dea the at hed fo	Physician/Med	in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				VIOLITI	Day	1 Bal
a	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th		Part II. Other significant conditions conf	tributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to t	he cause of	death?
Records,	uires sign	d by	Emphyse	na				101	res 2 No	3 Pro	bably 4 🗍	Unknown
CO	w requires to been s	iete	Caranary	in etak	950	ler 08	14	24a. Was	an 24t	o. Were auto	opsy findings	available
Re	The lav	Completed	and and	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100	, , , , , , ,		autop perfo 1 Yes	rmed?	prior to co death? 1 \(\text{Yes}	mpletion of a	ause of
Vital		BeC	25. Was case referred to medical				26. Place of Dea	ath (Check only o		10103	2/2/10	
of V	ys is	To E	examiner? 1 ☐ Yes 2 Mo		2 ER/Outpati		4 🗆 Nursing i	łome 5 X Resid			fy)	
	or Attending Ph ufter death. Director: After th in by the funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	Wor		28d. Describe h	now injury occ	urred		
isio	ttend death itor: /	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home form		Yes 2⊠No	28f. Location (S	Street and Nu	mher or Pur	al Poute Num	nhor
Division	or Attendiater death. Director: A	Certification:	4 Homicide determined	building, etc. (Sp	pecify)	street, factory, office		City or Tox	vn, State)	noer or rion	ar riodie rearr	iber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier Certifying Phys	ician: To the best of my	knowledge, dea	ath occurred at the tir	ne, date and place	, and due to the	cause(s) and	manner as s	stated.	
	he Ho n 24 } he Fu pletel)	edical	(Check only 2 Medical Examin	er: On the basis of exar and manner stated.	nination and/or	investigation, in my o	pinion, death occu	irred at the time,	date and place	e, and due t	o the cause(s	ş)
	To t To tl comp	ž	29b. Signature and title of certifier	0/		29c. Licens	_		29d. Date sign			
			the - Se	3/1/		000	56826	/	May	24	So	25
	6		30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type	e, Print)	56826 Paul 9	- 9	0	1		7 1-71-
	Sta	i	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	7 Dougt	rank 5	12021	40004	& Daro	MO	C1/1/2
	Regist		JUN 1 0 200			hard o						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Items 23b, pt. II. 27, 28a-1 per meo 8844 7-1-05 vt.

State of Maryland 7 Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26, 2005 May John Carroll Hinder, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City John R. Burton Pavillion Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 01/10/1928 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F 77 Yrs. Maryland Director 214-20-1025 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at Yes 2 No Director Aberdeen MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21001 619 Sadler Street Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1946-47 Year or Dates: Specify: 21215-0036 White δ er than "natural", o 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education within 72 ! (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Owner 0 12 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be and Mental h 8 Helen Kelly Frederick C. Hinder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau 619 Sadler Street, Aberdeen, Maryland 21001 Carolyn M. Hinder (Wife) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 1, 2005 Aberdeen, Maryland Harford Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) argnatule of Funeral Service Licensee Tarring Caroo Funeral Home, P.A. 333 South Parke Street, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) einvolus **Physician** monary /Medical Due to (or as a consequence of): water **Examiner** non-syncopal fall 5 4 11 0 Da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner ATTON APPROVED BY MEDICAL EXAMINER burial-tran and Due to (or as a consequence of) physician Box 68760 pe Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month for 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Ö 9 Unknown ۵ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

3e. Did tobacco use contribute to the cause of death?

Arterioscierotic cardiovascular Division of Vital Records, ٥ lation disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rib fractures autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 2 No 1 Yes ouvalin subarachnoid hemorrhage 26. Place of Death Check on one To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be Other 4 Nursing Home 5 Residence 6 X Other (Specify) Rhocaic Hosp Hospital: 2 ER/Outpatient 3 DOA ဥ 1 Xes ZXNo 1 Inpatient 28d. Describe how injury occurred funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 5 Pending investigation 1 ☐ Yes 2 No subject fell May 2005 unknown M death. Accident hours after deat hin 24 hours ... o the Funeral Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tollgate Park, BelAir, MD. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl one within To the License number 29d. Date signed (Month, Day, Year) 29b. Signature 05 Baltomore completed cause of death (Item 23a) (Type, Print) 30. Name and Hopkins Bayview Jerem Wa 21224

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Regultrar's Signature

1 2005

			State of Maryland / Department of Health and M 1- For State Registrar Certificate of Death		ene 005	19559
1	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Eldord M. Hatther Cher 4a. Facility Name (If not institution, give street and number) Custle Rd.4b. City, Town, or Location of Death	2. Date of Death Month May	Day Year	3. Time of Death GIZO PM
	Examin Funeral Director		43. Facility Name (if not institution), give street and mainter) 44. Facility Name (if not institution), give street and mainter) 5. Social Security Number 5. Social Security Number 5. Sox 1 M 2 F 89 Yrs. 44. Facility Name (if Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. Min. Min. Min. Min. Min. Min.	8. Date of Birth (Month, Day, 05-27-	Montgom	ery hplace (State or Foreign
	Maryland I-f ehow	tor	10a. State MD 10b. County Montgomery 10c. City, Town or Location Burtonsville			10d. Inside City Limits 1 Yes 2 □ No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 10f. Zip Code 20866	10	og. Citizen of What Co USA	ountry?
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28a-f ehow event, the Medical Examinar must be rictified at	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto of the Specify: 1 Yes 2 No Specify:	ocify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B	
21215-0036	d within 72 ho giene. or then "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary (Secondary (0-12) College (1-4or 5+) Teacher's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher's Aide	ng 1	Private	·
Maryland	ed la de	0	17. Father's Name (First, Middle, Last) Edward Burns 18. Mother's Name Lela		Maiden Sumame) teel	
	s 1 and 2 should f Health and Mer ftem 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Tanya LaSalle/ Daughter 5208 Lightfoot Path			
altimore,	permit. Pages 1 av Department of Hea Important: If item any injury or othe once.			Date 2	20c. Location - City or	
Balti	permit. Departr Importa any inji		21. Six fature of Pineral Service Licensee 22. Name and Address of Facility Tay 1722 North Capit 23a. Part 1. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	ol St.	NW Wash	Home DC 20002 Approximate
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	Examiner Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events.) Periode avents are disease or injury that initiated events.			
3760,	ate be executed hysicien and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Peripheral vascular disease Due to (or as a consequence of): Diabetes mellitys			
P.O. Box 68	The law requires that the death certifics to has been signed by the attending pt hage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of del Month	ivery Day Year
	quires that I n signed by ild be deta	by	Part II. Other significant conditions contributing to death out not resulting in the unberlying cause given in Part I.		acco use contribute to	
Il Records,		Completed		24a. Was an autopsy perform	y prior to death?	utopsy findings available completion of cause of
Vital	ysicien: Th s certificate director, pag	o Be	25. Was case referred to medical aximiner?		a) nce 6 □Other (Spe	cify)
o uo	Attending Physicien: The ir death. sctor; After this certificate hiby the funeral director, page	tion: T		28d. Describe ho		
Division of	el or Attendi s after death. Il Diractor: A id in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	reet and Number or Ru , State)	ural Route Number,
	To the Hospitel or At within 24 hours after of To the Funarel Diract completely filled in by	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	ate and place, and due	to the cause(s)
	7	×	29b. Signature and title of certifier Maria Roldmark, MD 29c. License number D 25344	29	od. Date signed (<i>Mont</i>	n, Day, Year)
	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Gold Mark 18020 3 hady 6 rove Rd Rock	ville M	id 200	50
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2005 Registrar's Signature			

			For State	State of Maryland / Department of Health and M Certificate of Death		2000 19550
	Dhysisi		Registrar 1. Decedent's Name (First, Middle, Last)	. / /	2. Date of Death Month D	o. 3. Time of Death ay Year
	Physici /Medic	al	Dorothy	Hudson	5 2	4 05 11:59 PM
	Examin Funeral Director	er	5. Social Security Number 6. Sex	oral Hospital Berlin	8. Date of Birth (Month, Day, Year	c. County of Death 10 5 (2.5 + 2.5 9. Birthplace (State or Foreign Country) 17 9 M
	death with the Maryland rms 23s or 28s-f show rms te redified at	'n	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-f	recto	10e. Street and Number	tor NOW HI//	10g. C	itizen of What Country?
	sath witi	Funeral Director	5546 Moat	Road 21863	181	U.S. A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or othar traumatic event, the Medical Examinar must be notified at one.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe tf Yes, specify Cuban, Mexican, Puerto I ☐ Yes, Specify: Year or Dates:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
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aryle	should nd Mer r marke umatic	To	19a. Informant's Name/Relationship y	De, Print) 19b. Mailing Address (Street and Number or Rura	Route Number, City	or Town, State, Zip Code)
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or othar traumatic event, If a Mones.		Robert Hudso.	w (husband 5546 Moat Road 20b. Place of Disposition (Name of	SNOW H	11, md, 2/861
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Balti	permit. Departm Importa eny inju		21. Signa ure Funeral Service License	22. Name alld Address of Facility & EA	wie Smit	h fun erol Hom.
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	Physician /Medical	Ì	Immediate Cause (Final disease or condition resulting in death)	idiopa Ric pulmoning F.5105.	is	Interval Between Onset and Death
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O. Box	equires that the death certificent signed by the attending tould be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
8, P. 8	es that thigh and the second part of the detaction of the second part		Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
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T. C. P.	ding Phys	n: To	27. Manner of Death	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hon	ne 5 Residence 8d. Describe how inju	
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Div	F 8 E C	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospital of within 24 hours af To the Funeral Completely filled in	edical	29a. Certifier 1	ician: To the best of my knowledge, death occurred at the time, date and place, a ler: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(sed at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	To the troining comp	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
			30. Name and address of person who con	Phy SIUL H 44283 mpleted cause of death (Item 23a) (Type, Print)	5/0	15/05
<	ET 5		31. Date filed (Month Day Year)	160 9733 HECITALLY Drive	Berli~	mD
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			For State Registrar	State of M	laryland /	Depa Cer	artment of H	ealth a Death	nd M		jiene ())5	19661
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	Funeral Director		234-36-6005	1 M 2 F	77	Yrs.	Months Days	Hours	Min.	Jan 25,	Year) 1028	Coul	place (State or Foreign ntry)
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	show	_	10a. State 10b. Count	eral	10c. City, To	own or Lo Ridge						1	10d. Inside City Limits
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	with th		10e. Street and Number	4			10f. Zip Code	0750		1	10g. Citizen of V		ntry?
	eath Rust	Funeral Director	34 Knobley Str	12. Was Deceden	t Ever in U.S.	13.		26753		cify Yes or No-	US 14. Bace		can Indian,
(0	r Itan	Fun	1 Never Married 2 Ma	Armed Forces	?		Was Decedent of His If Yes, specify Cubar		Puerto F	Rican, etc.)		k, White,	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign sture of Funeral Service	e Licensee	11	22	2. Name and Addres Scarpelli	s of Facility	al Ho	me PA			
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Вох	eath certific attending p	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal dea at time of death		Ectopic pregnancy Other (specify)				23d. Date Mor		ery Day Year
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rds	w require been sig should b							·		1 🗹 Ye	es 2□No	3 🗌 Prob	oably 4 □Unknown
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	10		30. Name and address of perso	~									
	Ψ		DR. SUNIL GUPT				CAL BLDG.	, 625	KEN	T AVE.,	CUMBER	LAND	, MD 21502
	Sta Registr		31. Date filed (Month, Day, Yea JUN 1	0 2005 32. Pogis	strar's Signature		well						

				State of Ma	ryland / De <i>C</i>	epartment of the Certificate of	Health and N <i>Death</i>		giene	05	19662
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21215-0020	be filed within 72 hours aftar death with the Maryland tal Hygiene. d other than "natural", or tlems 23a or 23a-f show evant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🏋 No		pecify Yes or No Rican, etc.)	Blac	e America k, White, e hite	
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an	Mental Mental Merked of	To Be	John Mehalick				Pauli	ne Bach	man		
ᡖ	g p E E	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. N	Mailing Address (Street				State, Zip	Code)
	nd 2 lith a 27 la		Nikki Lux/Daught	er	130	6 Red Brid	ge Road,	Pylesvi	11e,MD	2113	2
ore,	of Healt of Healt I Item 27		20a. Method of Disposition		20b. Place of D cemetery,	isposition (Name of crematory or other pla	ce)	Date	20c. Location -	City or Tov	vn, State
E	Pag ent ry o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emover from State	<u> </u>	agle Crema	1	/7/2005	Leola,	Penn	sylvania
Baltimore,	permit. Pa Departmen Important: any Injury pnce.		21. Signature of Funeral Servica License	90		22. Name and Addre Harkins Fune		c.,600 Ma	in St., D	elta, I	PA ` 17314
			23a. Part1. Epter the disease, or compli- shock, or heart failure. List only or	cations that caused the	he death. Do no	t enter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
To the	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	pue	ue to (or as a co	· i	/2		-0	-	Onset and Death
$\sqrt{}$	nstt	Ē		Cer	elen	Pom	elen.	any	les	i	
68760,	ficate be executed physician and is the burial-transit	al Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events		ue to (or es a co						
Box 687	leath certificate attanding phys d for usa as the	n/Medical	resulting in death) Last	l	ue to (or as a cor	rsequence or):				1	
P.O. B	at tha death I by the atta atached for	Physician/M	Part II. Other significant conditions con	tributing to death but	not resulting in the	he underlying cause gi	ven in Part I.		obacco use con Yes 2 No	ntribute to	the cause of death?
of Vital Records,	The law requires that tha death certificate be executed ate has been signed by the attanding physician and page 2 should be datached for usa as the bunal-transit	Completed by						24a. Was perfo	an autopsy rmed?	ava	re autopsy findings ilable prior to apletion of cause eath?
Re	has has ige 2	Ĕ						151	198 2 NO		eatii? Yes 2□No
ta			25. Was case referred to medical				26. Place of Deat				7105 2 110
>	Physician: this certific iral director,	o Be	eyaminer?	lospital:	t 2 ER/Outp	atient 3 DOA Ot			lence 6 □Oth	er (Specify)
		Ë	27. Menner of Death	28e. Date of Injury (Month, Day	28b. Tin	ne of 28c. Inju			now injury occurr		
<u>o</u>	Attanding In death. Cotor: After by the funal	ate	Neturel 5 Pending 2 Accident investigation	(Month, Day	Year) Inju		Yes 2□No				
Division	l or Atta after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	n, street, factory, office		28f. Location (S City or Tox	Street and Numb m, State)	er or Rural	Route Number,
	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A completaly filled in by tha fu	edical C			xamination and/	death occurred at the ti or investigation, in my o					
	within 2 To the	Z	29b. Signature end title of certifier			29c. Licen:	se number		29d. Date signe	d (Month, E	Day, Year)
			Da 135	D		03	227 9	5	Tune	2,2	00-
	1		30. Name and address of person who co	mpleted cause of dea	ath (Item 23e) (T	/pe, Print))			-	
	.1		DR. DAVID DUNN -	615 W. M		ROAD - I	BEL AIR, N	1D. 210	14		
	Sta	4.	31. Date filed (Month, Day, Year)	32. Pegistrer	's Signature	de di					
DHI	Regist		JUN 1 0 20	J. J. Sept. 14	v B.	Speciel .					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day TOINES **Physician** HAZEL 1115A M 2005 26 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL TAKOMA PARK, MARYLAND WASHINGTON ADVENTIST MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🗓 F Yrs 91 May 1, Director 042-07-4860 1914 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event, if a Medical Experit errount to notified at 1 X Yes 2 □ No Director Prince George's Maryland Brentwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3411 Upsher Street 20722 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. ☐Yes 2MNo Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ρ Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) th and Mental Hy Be Kellie Gwen Jervis Audie May Hentsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 ls 5729 Lockwood Road, Cheverly, Maryland 20785 Russell F. Joines - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Importent: If it 70 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 与☐ Other (Specify) Whitehead-Joines Cemetery 5/30/05 Sparta, North Carolina 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Causa (Disease or injur that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Anteny Disease Aortic Coronary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hypertension 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.0. Records, **Division of Vital** Director: 50 24 hours a within 2

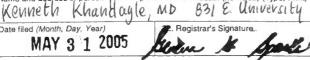
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifier

29b. Signature and



no completed cause of death (Item 23a) (Type, Print) { QUE, MD 831 & UNIVEVSITY

State MAY 3 1 2005 Registrar

determined

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D61007

Blvd #25 Silver Spring, MD 20903

29d. Date signed (Month, Day, Year)

MAY 26, 2005

			For State Registrar		State of	Marylar	•	artmen rtificat			and M	lental Hy	giene Reg. No	11115	The second secon	564
П	Physici	an	1. Decedent's Name (First,	Middle, Last)								2. Date of De Month		Year		of Death
П	/Medic		KNOVELL				JA	CKSON				MAY	28		1:34	РМ
	Examin	er	4a. Facility Name (If not inst PRINCE GEOR	-					Town, or VERL	Location o	of Death			County of Dea		C
			5. Social Security Number	6. Sex			last birthday)	If Under		If Under	24 Hrs.	8. Date of Bi		RINCE (
	Funeral Director		231-32-2649 Usual Residence of Decede	1 🔯	M 2□F	73	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D. JULY			rthplace (State Country) RGINIA	
	/land		10a. State 10b. C			10c. Ci	ty, Town or Lo	cation							10d. Inside	City Limits
	Man,	ţō	MD PRI	NCE GE	ORGE'S	L	ANHAM								1 X □ Y∈	s 2∏No
	or 28	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Cit	zen of What C	country?	
	23a	al	6611 MANTON	WAY					706					S.A.		
	ar deg	nue	11. Marital Status		 Was Decede Armed Force 	es?	.S. 13.	Was Deced	tent of Hi ofy Cuba	spanic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	0-	 Race - Am Black, Wh 		
36	rs aft	by F	1 X Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 ☐ Yes 2 If Yes, Give Year or Date			1 🗆 Yes	2X No	Specify:				Specify:	BLACK	
Ş	72 hours after death with the Maryland Insturet; or Itams 23s or 28s-f show Ital Extening must be notified at	ed	15. Dec	edent's Edu	cation		16a. Dece	dent's Usua	al Occupa	ation			16b. K	nd of Busines		
212	.s ~ #	plet	(Specify only Elementary/Secondary (0		College (1-4	or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	luring mos)	t of work	ing			,	
21215-0036		Completed	7th				LABO	RER					P	RIVATE		
p	of ta b	Be	17. Father's Name (First, M.		NT.							e (First, Middle		Sumame)		
<u>\\ \ \ \</u>		²		JACKSO:			404 14 18			MYRT			EEN			
Maryland	d 2 Tha		19a. Informant's Name/Rela		STEPDAU	GHTER						al Route Numb MARYL		20706	Zip Code)	
Ē,	s 1 an of Heal Item 2 other		20a. Method of Disposition				Place of Dispo cemetery, crei	sition (Nar	ne of ther place	9)	- 1	Date	20c. Lo	cation - City o	r Town, State	
Baltimore,	rmit. Pages 1 partment of H portant: If Ite y Injury or ot		1 ⊠Burial 2 ☐ Crema 1 ☐ Donation 5 ☐ Oth		emoval from Sta	are i	OVIDENC			-	6/4	/2005	A	YLETT,	VIRGINI	A
a	Departm Departm Importal any inju		21. Signature of Funeral Se	rvice License	98 / //	1/	22	2. Name an	d Addres	s of Facilit	у Ј	. B. JE	NKIN	S FUNER	RAL HOM	E
_	20129		X.D.	you.	hal							LANDO		MARYLA	ND 207	785
	Pnysician /Medical	SE V	23a. Part1. Enter the diseashock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or compli List only or	e cause on eac	th line.	Valve					or respiratory a	arrest,		Approxim Interval B Onset and	etween
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.O. Box 6	The faw requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 Yes 2 No 9 Unknown	nt		h 2∏Feta nt at time of c	aldeath 3∐	Ectopic pr						23d. Date of de Month	alivery Day	Year
rds, P	quires that n signed b	ρ	Part II. Other significant co	nditions cor	ntributing to dear	th but not res	sulting in the u	nderlying c	ause give	n in Part I.	,			se contribute t	to the cause of Probably 4	
Vital Records,	e taw requiri has been si je 2 should l	Completed	Atrial fib	rillatio				<u> </u>				24a. Was		24b. Were a prior to death?	utopsy finding completion of	s available cause of
a			Prostate	Canc	er							1 ☐ Yes	2 N O	1 ☐ Ye		
Ħ	Physician: this certifica ral director, p	o Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 ☐ №6		lospital:		IED/Out-stier		Othe	r.		h (Check only			- 16)	
on of	ding h. After fune		27. Manner of Death 1 DNatural 5 T	ending	1 Inp 28a. Date of (Month,		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 140		me 5 Res 28d. Describe			өсіту)	
Division		ertification;	3 ☐ Suicide 6 ☐ C	Could not be etermined	28e. Place of building	f Injury - At h , etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factory	r, office			28f. Location (City or To			Rural Route Nu	mber,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Phys dical Examin	sician: To the base. On the base and manne	is of examina	owledge, death ation and/or in	h occurred vestigation	at the tim , in my op	e, date an sinion, dea	d place, th occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause	(s)
	To the within 2 To the I complet	Me	29b. Signature and title of o	ertifier						number				e signed (Mon		
1	7)		5				DOT	431	663		5/	29/05	5	
)	(6)		30. Name and address of p	Boyce	Pattos	V Hal	30	01	HUS	Pho	rc	DV C	her	evky A	10 20	785
	Sta Registi		MAY 3		Blown	~ *	ature	Les .								

			1 - For State Registrar	State of	Maryland / De	partment ertificate			and Mental H	ygiene Reg. No. (105	19665	
	Physici	an	Decedent's Name (First, Middle,		i				2. Date of D Month	eath Day	Year	3. Time of Death	
	/Medio		4a. Facility Name (If not institution,	KELLY		4b. City, T	Town, or L	ocation o			Day Year G + O AM 4c. County of Death		
1	Examil	ier	Anne Arundel Med	•	·		apol		204		Anne Arundel		
	Funeral Director		5. Social Security Number 573-40-2394 Usual Residence of Decedent	Sex 7 1 M 2 □ F	. Age (In yrs. last birthd 71 Yrs	Months	1 Year Days	Hours	Min. Dec. 7	irth Year) 33	9. Birtl Oh 1	hplace (State or Foreign untry) O	
	/land		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits	
	a-fst	ctor	Maryland Anne	Arundel	Annapo	is						1 ☐ Yes 2 No	
	th with the 23e or 28 unt be no	Funeral Director	10e. Street and Number 1690 Winchester	Road		10f. Zip (214)					of What Co		
36	s 1 and 2 should be filled within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I Health and Mental Hygiene. I Health and I show item 27 is marked other than "neturel", or items 23e or 28e-1 show other treumatic event, I're Madical Exeminer mark be notified at	by Fune	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Force 1 Yes 2 If Yes, Give Year or Dat	No	3. Was Decede If Yes, specif		panic Orig , Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)		Race - Ame Black, White ecify: wh		
21215-0036	72 hou	ted	15. Decedent's (Specify only highest	Education	16a. De	cedent's Usual	Occupat	ion	a function	16b. Kind	of Business/l		
121	/ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4	10f 5+)	ve kind of work DO NOT use	e retired)	iring most	or working	NI			
2	filad withir Hygiene. other than ent, II.e M.		17. Father's Name (First, Middle, La	Z istl	0.	ficer	1	18 Mothe	r's Name (First, Midd	Navy	mame!		
au	ould ba Mental arked o	To Be	Russell Kelly	/					lie Strahl	o, maidon ou	mame)		
Maryland	2 should I and Meni Is marke	-	19a. Informant's Name/Relationship	(Type, Print)	19b. M	iling Address ((Street an		r or Rural Route Num	ber, City or To	wn, State, Z	Tip Code)	
	1 and 2 Health a em 27 ls		Joan Kelly/ wife						. Annapoli	s, MD 2	21401		
Baltimore,			20a. Method of Disposition 1	☐Removal from St	20b. Place of Discemetery, of	position (Name rematory or oth	e of her place))	Date	20c. Locati	on - City or	Town, State	
Ē	그 문문구		' 4 □ Donation 5 □ Other (Spe		Arlingt	on Nat.	Cen	n. 7	-19-2005	Arling	ton, Y	7.A	
Ba	permi Depa Impo any ir		21. Signature of Funeral Service Lic	Roman		.47 Duke	e of	Glou	cester St	. Annap	unera olis,		
	Pnysician		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on eac	ch line. Cardioazni	¿ 51	hock	<		arrest,		Approximate Interval Between Onset and Death 5 10025	
	/Medical Examiner		resulting in death)	Due to (or	rasa consequence of):		, .	1	faichm			- 110	
		ler	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or	r as a consequence of):	yocana	diff.	m	pacolin			5 HV0/45	
	cate be executed physician and the burial-transit	Examine	that initiated events	с.									
90,	oe exe cian a nurial-i	I Ex	resulting in death) Last	Due to (or	r as a consequence of):								
8760,	icate b	dicai		d.						_	-		
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	nt at time of death	3 □Ectopic pre 5 □ Other (spe				23d.	Date of deli	very Day Year	
Ω.,	that the		Part II. Other significant conditions	s contributing to dea	th but not resulting in the	underlying ca	use given	n in Part I.	23e. Did	tobacco use o	contribute to	the cause of death?	
rds	w requires baan sign should be	ed by	Diabete	o Mellin	lio				1	Yes 2 🖳	0 3 □ Pro	obabiy 4 🗆 Unknown	
of Vital Records,	The law reste has bee page 2 sho	Completed	Hype	o Mellit Hensim					per	opsy formed?	prior to c death?	topsy findings available ompletion of cause of	
ital		Be C	25. Was case referred to medical examiner?				2	26. Place	of Death Check onl	2 No	1 🗆 Yes	2 No	
of V	Physician: this certific ral director,	은	1 Yes 2 No		patient 2 ER/Outpar		-	4 🗀 1401	rsing Home 5 🗆 Res			ily)	
	ling After fune	tion:	27. Manner of Death 1 Natural 5 Pending		Injury 28b. Time Day Year) Injur	of 28	c. Injury a Work?	at es 2 □ N		how injury oc	curred		
Division	or Attending after death. Director: After in by the fune	fical	2 Accident investigat 3 Suicide 6 Could no	t be 28e. Place of	f Injury - At home, farm,					(Street and N	umber or Rui	ral Route Number,	
Ö	i ji fi g	Certification;	4 Homicide	building	g, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,				own, State)			
	To the Hospitel or within 24 hours after To the Funerel Direct completely filled in I	edical (29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	est of my knowledge, de is of examination and/or r stated.	ath occurred at investigation, i	t the time in my opir	, date and nion, deat	d place, and due to the h occurred at the time	e cause(s) and , date and pla	manner as ce, and due	stated. to the cause(s)	
	To t To ti comp	M	29b. Signature and title of certifier	HINTON CONTRACTOR			License r			29d. Date si	7		
•			1	9			D4	11534	4	0	5/29	105	
			30. Name and address of person whether	o completed cause	of death (Item 23a) (Typ	e, Print)) 、フッコ	2 M	leder.	O Paulonia	y Sui	le suc	Annapolis Moditoi	
	Sta		31. Date filed (Month, Day, Year)	- 40-	gistrar's Signature	coulds	-		/	1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Registr	ar	MAY 3 1	2005	Me of the								

			. For	State of Maryla		artment of F				
			1 - State Registrar		Ce	rtificate of	Death		Reg. No.2 0 0 5	9666
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month	Day Year	3. Time of Death
	/Medic	cal	Edward Louis KEAR			4b. City, Town, o	or Location of Deat	May	30 2005 4c. County of Dea	
100			Avalon Manor Nurs			<u> </u>	stown		Washing	
- ji. €:	Funeral Director	.===	15/-14-/565	x 7. Age (In y. 79	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			rthplace (State or Foreign Jersey
the free	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary Inc.	to	Maryland Washing	ton	Hagers	rown				1 Yes 2 □ No
	or 288	Director	10e. Street and Number		110,6220	10f. Zip Code	_		10g. Citizen of What C	ountry?
	ath wi	ral	901 Rose Hill Ave				740		U.S.A.	
36	d within 72 hours after death with the Maryland liene. r than "natural", or items 23s or 28s-f show It a Me Jical Evana or must be notified at	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Kore		Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 🂢 No		Specify Yes or No to Rican, etc.)	Specify:	
Maryland 21215-0036	in 72 hou	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Business	
212	d within giene. ir than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	M	ilitary P	olice		Milita	ry
nd	be filed tal Hygie d other event, I	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na.	me (First, Middle,	, Maiden Surname)	
yla		ပ	Richard Kearns					a unkno		
Mar	O 0 30 M		19a. Informant's Name/Relationship (T)			ng Address (Street Rose Hill			er, City or Town, State,	
	s 1 and 2 if Health item 27 other tra		Nancy Hardy - Dau 20a. Method of Disposition	206	. Place of Dispo	osition (Name of matory or other place		Date	20c. Location - City o	
E	0 0		1 ☐ Burial 2 X Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		•	own Crema		/05	Hagerstow	n, Maryland
Baltimore,	permit. Pag Department Importent: t any injury o		21. Signature Funeral Service Licens		22	2. Name and Addre	ss of Facility	Minnich	Funeral Ho	me
	20229		cotto,	1.11/imne					erstown, Md	T
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a Congo	stive		rd, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a cons	equence of):	4 AV	tery	O:	sease	
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	<u> </u>	1	1.			
, 0	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
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.O. Box 68	The law requires that the death certifical te has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	blivery Day Year
<u>α</u>	that the ned by detac	by Ph	Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
rds	w requires t been signe should be							1 🗆 '	Yes 2□No 3□P	robably 4 Unknown
Vital Records,	The faw requate has been page 2 should	ompleted						24a. Was autor perfo 1 Yes		utopsy findings available completion of cause of
/ita	sicien: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?			2004		ath (Check only o		
of\	Phys this al dir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier		4 Nursing F		dence 6 Other (Spe	ecify)
ion	Sing After fune	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,) Injury	Wor	rk? Yes 2 □ No	284. 2630.106	now injury occurred	
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)			City or To		
	To the Hospitel or within 24 hours afte To the Funerel Discompletely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To the within 2 To the complet	W	29b. Signature and title of certifier	ompleted cause of death (I		D C	0 6 0 T	396	29d. Date signed (Mon	th, Day, Year)
4-	-1		30. Name and address of person who c	ompleted cause of death (I	tem 23a) (Type	Print) 11 1	Huger	pal	MD 2	1740
	Sta Regist		31. Date filed (Month, Pay Year) 1 2	2005 32. Redistrar's Sig	gnature	perke			,	

			For Stete Registrar	State of M	laryland /		artment of H			giene2 () ()	5 19667
	Physici	an	1. Decedent's Name (First, Middle		0 . =				2. Date of Dea Month	ath Day Ye	3. Time of Death
	/Medic Examin		KENNETH 4a. Facility Name (If not institution)				4b. City, Town, or	Location of Deat	MAY h	26 20 4c. County of I	
	Examin	er	Bowie Health		/		Bowie	LOCATION OF DOCE			Georges
	Funeral		5. Social Security Number		ge (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt Oct. 4	h 9.	Birthplace (State or Foreign Country)
	Director		220-34-3866 Usual Residence of Decedent	1 ⊠ M 2□F	68	Yrs.	Monta Dayo	110010	0ct. 4	, 1936 _W	est Virginia
	yland		10a. State 10b. County		10c. City, To	own or Lo	ocation			· · ·	10d. Inside City Limits
	e Mar	ctor	Md. Prince	Georges			Bowie	!			1 AYes 2 No
	with th	Funeral Director	10e. Street and Number				10f. Zip Code	0716		10g. Citizen of Wha	at Country?
	eath v	eral	3434 Elenoir C	12. Was Deceden	Fver in U.S.	13 1		.0716	pecify Ves or No.	USA	American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, If a Modical Examination and be notified at once.	by Fun	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	? No		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 Ho	Specify:	o Rican, etc.)	Black, \ Specify:	White, etc. White
5-0	72 ho	eted	15. Decedent (Specify only highes		16	6a. Dece	dent's Usual Occupa kind of work done d	tion uring most of wo	rkina	16b. Kind of Busin	ess/Industry
121	filed within Hygiene. Ither than	Completed by	Elementary/Secondary (0-12)	College (1-4or		life.	DO NOT use retired) Electr			Electri	ca1
0	filed v Hygie other I	ပိ	12 17. Father's Name (First, Middle, I	Last)					ne (First, Middle,	Maiden Sumame)	
Maryland 21215-0036	should be nd Mental marked o	To Be		Kenneth M					auline Sa		
	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationsh Sandra Kimble		1		ng Address <i>(Street</i> a Elenoir				
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		20b. Place ceme	of Dispo	sition <i>(Name of</i> matory or other place tan Crema	tory 05	Date -31-05	20c. Location - City Alexandri	
altin	permit. Pa Department Important any injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral envice I		M		. Name and Address			neral Hom	
<u> </u>	8988		100	J DX	W		512 N.W.				
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each	od the death. D	o not ent	I	rilla		rest,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as	a consequence	ce of):	Card	iomu	10 pa	tha.	73 4rs
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oʻ	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequence	ce of):	17 Ea	~ 1	21340	(36	1913
8760,	icate be physici the bu	dlcal		d							
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ords	w requires that been signed k should be deta	ted t	Ventricu	lar S	epta		Kepa	11	1 🗆 Y	es 2 No 3	Probably 4 Unknown
Reco	<u>a</u> a c	Completed							24a. Was a autop perfor 1 \(\supers \text{Yes} \)	sy prior	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho		ath (Check only or	,	600
on of	ding Phys h. After this of funeral dir	lon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury 28t	Outpatien b. Time of Injury	28c. Injury Work	at		ence 6 ther (Special ealth enter
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of Ir	ijury - At home, tc. <i>(Specify)</i>	, farm, str	eet, factory, office	30 20.10	28f. Location (S City or Tow	treet and Number o n, State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filted in	edical C	29a. Certifier 1 Certifying (Check only one)	g Physician: To the besi Examiner: On the basis and manner s	of examination	dge, death and/or in	occurred at the time vestigation, in my op-	e, date and place inion, death occu	, and due to the our irred at the time, o	ause(s) and manne late and place, and	or as stated. due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manners	tateu.		29c. License	number	, 1	29d. Date signed (M	fonth, Day, Year)
)			* eskuta	lun 80 n	MD		D5	-0011	5	May 2	7,2005
R	(2)		30. Name and address of person of BARBARA		death (Item 23a	a) (Type,	Print) 388 Be	staat	o Rd	Annapi	7,2005 olis MO
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature			J. 1	· not	111000	
	Registr	ar	MAY 3 1 20	JUJ Slave	M.	Charle					

05-3834 B.K.S BONNIE DEE KENNELL 1- Stat

Please Type or Print in	Black Indelible Ink. Ensure All (Copies Are Legible.	
State of Marylar	nd / Department of Health and Me	ntal Hygiene	
	Certificate of Death	Reg. No. 005	No. of Lot, Lot, Lot, Lot, Lot, Lot, Lot, Lot,

	•
Physician	
/Medical	_
Examiner	4

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

		1 - State Registrar	erti	ficate o	of D	eath		Reg. N	16. U	Jo	19668
		1. Decedent's Name (First, Middle, Last)					2. Date of)av	Vear	3. Time of Death
ysici: Aedic		Bonnie Dee Kennel	l				JUNE	4,	²⁰⁰ 200	5 ' " "	3:31 P M
amin		4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL		tb. City, Tow CUMBER		ocation of Deat	h		4c. County ALLE	of Death	
eral ctor		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	1	If Under 1 Ye Months Da		f Under 24 Hrs Hours Min.	8. Date of Sep 2	Birth Day, Yea 26, 1	976	9. Birthp Cou	place (State or Foreign ntry)
		Usual Residence of Decedent	. 1								104 1-14 02 11-14
any injury or other traumatic event, the Medical Everth ar must be notified at once.	ctor	MD Allegany 10c. City, Town of Cun		erland							10d. Inside City Limits 1 Yes 2 □ No
Die Do	Director	10e. Street and Number 515 Furnace Street		10f. Zip Coo		1502		10g. (of to nexistic	What Cour	ntry?
TIMES!	era		13 Wa	s Decedent		anic Origin? (S	necify Yes or	No-			can Indian,
th ser	Funerai	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Y	es, specify (Cuban,	Mexican, Puer	to Rican, etc.)		Bla	ck, White,	etc.
E	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give ↑ Year or Dates:	1 Ĺ	Yes 2	No .	Specify:			Specif	່ ^{ນ:} whit	e
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ant, III	e Co	17. Father's Name (First, Middle, Last)	<u> </u>	Alu	18	8. Mother's Na	me (First, Mide				
natic eve	To B	Richard Leslie Kennell				Edith V					
er traun				urnace		d Number or Ri reet		nber, City			21502
r oth		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State					Date			- City or To	
jury		`4 □ Donation 5 □ Other (Specify) Sunset IVI					6/8/2005		umbe	erland	I MD
any in		21. Signal fred Funeral Service Licensee	22. N			uneral H			4 MD	21502	
		23a Part I. Error the disease, or complications that caused the death. Do not	enter			iia Avenu such as cardia			רחואר יר	21502	Approximate Interval Between
ian		shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition									Onset and Death
ical		resulting in death) a. Due to (or as a consequence of):	:								
iner		Sequentially list conditions, b.									
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as the burial-transit		d									
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hed fo	Physicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown		Other (specif)				-	IVIC	JIIIII	Day Teat
detac		Part II. Other significent conditions contributing to death but not resulting in the	ne unde	erlying cause	given	in Part I.	23e. Di	d tobacc	o use cont	tribute to th	he cause of death?
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nous	Completed						24a. W				ppsy findings available
age	omb						pe	topsy rformed? 2 1	,	prior to co death? 1 Yes	mpletion of cause of
ctor, p	BeC	25. Was case referred to medical examiner?			2	6. Place of De					
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unere	ion	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury 28b. Tim Injury 28b. Tim			njury at Work?	t s 2∭2No	28d. Describ		here	-1	self
the i	licat	2 Accident	70'	t factory off		S 2 S NO	28f Location	(Street	and Numb	ber or Rura	al Route Number,
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y fille		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, d	leath o	occurred at th	e time,	date and place	e, and due to t	ne cause	(s) and ma	anner as s	allegan Co.
pletel	edical	(Check only one) Medical Examiner: On the basis of examination and/o and manner stated.	or inves	stigation, in r	ny opin	ion, death occu	irred at the tim	e, date a	ind place,	and due to	o the cause(s)
com	M	29b. Signature and title of certifier		29c. Lic	oci				JUNE		Day, Year) 2005
3		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Pr	int) 111 Pa	חחי	Street	Balti	more	. Ma	rvlan	nd 21201
Sta	ite	31. Date filed (Month, Day, Year) 32. Segistrar's Signature			-1111	201000	24161				
gistr		JUN 1 0 2005 Street &	100	The same			<u> </u>	_			
ev 1/2	001										

Registrar

			1 - For State Registrar	State of Maryland / D	epartment of Health and Certificate of Death	•	05 19669	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Grayson	Eugene Klip	pp	2. Date of Death	3. Time of Death 1:12 A. M	
	Examir		4a. Facility Name (If not institution, give s 11217 Lake		4b. City, Town, or Location of Dea Hagerstown		4c. County of Death Washington	
	Funeral Director		5. Social Security Number 219-20-4070 6. Sex 1♥	M 2□ F 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hr. Months Days Hours Mir		9. Birthplace (State or Foreign Mary Land	
10	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deputriment of Health and Mental Hyglene. Important: if Item 27 is merked other than "natural", or Items 23e or 28e-1 show any njury or other traumatic event, Ite Modical Examination and any once.	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washing 10e. Street and Number 11217 Lakeside Dr. 11. Marital Status 1 Never Married 20 Married		Hagers town 10f. Zip Code 21740 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	10d. Inside City Limits 1 □ Yes 2 □ No of What Country? J. S. A. Race - American Indian, Black, White, etc.	
d 21215-0036	filed within 72 hours a Hygiene. kthar than "natural, o ant, the Medical Exen	e Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 11. Father's Name (First, Middle, Last)	Year or Dates: 194/ ation completed) 16a. [College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of we life. DO NOT use retired) Driver	16b. Kind o	Construction	
Maryland	2 should be filed within and Mental Hygiene. is marked othar than aumatic evant, Ibe M.		Samual Milton Klipp 19a. Informant's Name/Relationship (Tyx	e, Print) 19b.		Irene Cline		
	es 1 and 2 of Health a f Itam 27 is r other trau		Alberta Viola Klip	20b. Place of I	217 Lakeside Drive Disposition (Name of Committee of or other place) ed Spires Cemetery	Date 20c Location	on - City or Town, State	
Baltimore,	permit, Pages 1 and Department of Health Important: If Itam 27 any njury or other tr		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	M0002] ations that called the death. Do no	22. Name and Address of Facility Keeney and Bas 106 Fast Churc	ford Funeral h h Street, Fred	erick, MD 21701 Approximate Interval Between	
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Records, P.	The lar ate has page 2	Completed by P	Part II. Other significant conditions con	ributing to death but not resulting in	the underlying cause given in Part I.	1 √es 2 □ No	ontribute to the cause of death? 3 Probably 4 Unknown b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
Division of Vital	ling Physician: After this certific funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Hold Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 ☐ Inpatient 2 ☐ ER/Outs 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farr building, etc. (Specify)	patient 3 DOA Other: 4 Nursing me of ury M 1 Yes 2 No	aath (Check only one) Home 5 Residence 6 C 28d. Describe how injury occ 28f. Location (Street and Nu City or Town, State)		
Ω	To the Hospital or Attenc within 24 hours after death To the Funaral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one)	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	ce, and due to the cause(s) and curred at the time, date and place	manner as stated. ce, and due to the cause(s)	
)	To the within To the compl	Me	29b. Signature and title of certifier Muchoel /	· Miloun	29c. License number 9 4 16 6 7		ned (Month, Day, Year)	
	5		30. Name and address of person who(cor	Clormack 11	Type, Print)	Cuma Hage	.6.05	
	Sta Regist	rar	31. Date filed (Month, Day, Year) JUN 1 0 2	32. Registrar's Signature	South	, ,,		
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			State Registrar	Land	Cei	runcate of L	Jealii	Reg. 2. Date of Death	No.	3 Time of Dea	
	Physicia	ın	1. Decedent's Name (First, Middle, I	L Mile				Month	Day Year	3. Time of Dea	м
	/Medic			D. Ly/C		4h City Tours or	Location of Death	May 28,	4c. County of Deal		M M
	Examin	er	4a. Facility Name (If not institution, g								
			4162 Carrs Ridg 5. Social Security Number 6.	E KO. 7. Age (In yrs.)	last hirthday)		dgewater	8. Date of Birth	Anne Aru		reian
	Funeral Director		219–34–3845	1□M 2XF 78	Yrs.	Months Days	Hours Min.	(Month, Day, Ye 7-9- 1926	-	hplace (State or For untry)	
		-	Usual Residence of Decedent	70			1	7-3- 1326	o inew	Jersey	
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Lir	mits
	Man	to	Maryland Anne A	rundel	Edgewa	iter				1 □ Yes 2 🔀	No
	r 28s	Directo	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?	
	h witi		4162 Carrs Ridg	e Rd.		210)37		USA		
	deat ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Ame Black, Whit		
ဖွ	after or ite	교	1 Never Married 2 Married			1 ☐ Yes 2 ☐ No	Specify:	,	2 "		
<u> </u>	be filed within 72 hours after death with the Maryland Hygiene. Hygiene do they then "neturel", or items 23a or 28a-f show event, the Madical Examinat must be notified a went, the Madical Examination and the models.	d by	3X Widowed 4 □ Divorced	Year or Dates:					77	hite	
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Maryland 21215-0036	ed tal	Be	Vernon Ed					hel Grime			
Ĕ	s 1 and 2 should be f Health and Mental item 27 te marked other other treumatic ev	P	19a. Informant's Name/Relationship		19h Maili	ng Address (Street	and Number or Rura			Zin Code)	
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	1 and 3 Health Bm 27 ther tr		20a. Method of Disposition	20b. F	lace of Dispo	osition (Name of			c. Location - City or		
ŏ	Pages nent of I ant: if its ary or o		1 Burial 2000 remation 3	I ⊟Removal from State 77.		matory or other place !rematory	6-2-	05 5	Edgewater	MD	
Baltimore,	rt. Partmer rtent rtent njury		* 4 □ Donation 5 □ Other (Spe 21. Signatur	,						•	
Bal	permit. Pages 1 and Department of Health Importent: if item 27 any injury or other tr once.		16 July 1 lla	L			^{ss of Facility} Geo ons Islan				
			23a. Part1. Enter the disease, or co	omplications that caused the deat	h. Do not en	ter the mode of dyin	ng, such as cardiac o	r respiratory arrest.	,	Approximate Interval Between	n
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	nd rans	Examiner	Cause (Disease or injury that initiated events	с							
Ö,	ate be executed hysician and the burial-transit	Ë	resulting in death) Last	Due to (or as a conseq	uence of):						
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9	tiffic as as	Med	IF FEMALE:								
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of Vital Record	Physician: The la r this certificate has ral director, page 2	10	1 Yes 2 No	1 Inpatient 2	ER/Outpatie	INI 3LI DOA	4 Nulsing Ho	me 5 X Residence 28d. Describe how		cify)	_
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S	de de de de de de de de de de de de de d		4 Homicide determin	building, etc. (Special	hy)	aroot, radiory, ombo		City or Town, S	State)		
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Division	spital or Attencours after death ours after death serel Director: filled in by the	ai Certification;	29a. Certifier 1 Certifying	Physician: To the best of my kno	owledge, deat	th occurred at the tir	me, date and place,	and due to the caus	se(s) and manner a	s stated.	
Divis	e Hospital or Attel 24 hours after des 8 Funerel Directol etely filled in by th			Physician: To the best of my kno xaminer: On the basis of examina and manner stated.							
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			For State Registrar		State	of Ma	ryland /	-	artmen rtificat				lental Hy	giene Reg. No	UU)	1967	B
	Physici	an	Decedent's Name (First		ast)								2. Date of De Month	Da	y Y	ear	3. Time of De	
	/Media	al	Sara Jean Lo		ve street and i	number)			4b. City.	Town, or	Location	of Death	JUNE	2	20 County of		18:28	> M
	Examir	er	Washington (erst				1	Washir		n	
	Funeral		5. Social Security Number	6.	Sex 1 □ M 25√2 F	7. Age	(In yrs. last		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Di				lace (State or F	-oreign
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	he Ma 18e-1 s	ecto		shing	ton		Hage	erst									1 ∏ Yes 2	□ No
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Itams 23a or 28e-1 show any njury or other traumetic event, the Madical Examines and be natified at once.	by Funeral Director	11. Marital Status 1 XNever Married 2 3 Widowed 4 Di		1 □ Ye If Yes,	Forces? s 2 XNo		į.	Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	D-	14. Race - Black, ' Specify:	White,	etc.	
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/ita	Physicien: The this certificate has all director, page	Be (25. Was case referred to rexaminer?	nedical	l la se in l							of Death	(Check only o	one)				
of	Attending Physicien: r death. sctor: After this certifics by the funeral director, I	lon: To		Pending	28a. Da (M	Inpatient te of Injury onth, Day	281	Outpatier b. Time o Injury		Bc. Injury Work	at		me 5 Resi 28d. Describe			Specify)	
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	To the Hospitel or Attending PP within 24 hours after death. To the Funeral Diractor: After the Completely filled in by the funeral	edical Ce	29a. Certifier 1 C (Check only one) 2 M	ertifying Pedical Exa	miner: On the	the best of basis of e	examination	dge, deat and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manne I place, and	er as sta	ated. the cause(s)	
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State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 27, 2005 Year Mildred Lee Lopez <u>3:0</u>7 a [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 09/07/1940 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1□M 2ਊF Director 213-36-9604 64 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified a 1 Yes 2 No Directo Maryland Aberdeen Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a Completed by Funeral 65 Greene Ave. 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 librarian education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event <u>once.</u> Be Margaret Schmidt Lee Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Lopez Stumpf (daughter) 606 Hollen Road, Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Harford Mem. Gardens 6/2/2005 Aberdeen, Maryland 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each time. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events signed by the attending physician and does detached for use as the burial-tran resulting in death) Last Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 1 Enpatient 2 ER/Outpatient 3 DOA uneral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Natural 2 Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Startifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20211 3 30. Name and address of person who completed cause of deat | (Item 23a) (Type, Print) avenue, 601- S. Unim 31. Date filed (Month, Day, Year) MAY 3 1 Aegistrar's Signature State Registrar

			For State	State of Maryland / Dep	artment of Health and M rtificate of Death	/	11115 10673
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	Tillicate of Death	Reg. No. 2. Date of Death	3. Time of Death
2	Physicia			-ittleton			B 2005 5:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death		c. County of Death
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15.	Funeral Director		5. Social Security Number 6. Sex 1 Number 1 1 Number 1 Nu	7. Age (In yrs. last birthday, 4 2 X F 64 Yrs.	12.1	8. Date of Birth (Month, Day, Year 5 / 6 / 1941	9. Birthplace (State or Foreign Country) USA
			Usual Residence of Decedent			7,0,1011	
	anylan show	_	10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 No
	ours after death with the Marylan rel; or items 23e or 28a-f show Examit er mart be notified at	Director	MD Worceste	r Bishor	10f. Zip Code	10g C	Citizen of What Country?
	with t		10e. Street and Number	D.L. D.O. D 30			
	leath ns 23	Funeral	10/0/ BISNOPVIIIe 11. Marital Status	Rd. P.O. Box 29 . Was Decedent Ever in U.S. 13.	21813 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		Worcester 14. Race - American Indian,
(0	r iter	교	1 ☐ Never Married 2 Married	1 □Yes 2 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	Hican, etc.)	Black, White, etc.
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d 2	Hygie other		17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maide	en Surname)
an	buld be Mental arked o	To Be	Oliver A. Tingle		Ruth I	Harvev	
Maryland	ds br E E	-	19a. Informant's Name/Relationship (Type	p, Print) 19b. Mai	ling Address (Street and Number or Rur	ral Route Number, City	or Town, State Zin Code) Bishopville, M X 29, 21813
	l and 2 s tealth ar m 27 is her trau		Vincent G. Little			P.O. Bo	ox 29, 21813
Baltimore,	ges 1 ar t of Hea if item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re.	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date 20c.	Location - City or Town, State
Ĕ	nit. Pages partment of orient: If it injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Riversio		and the second s	ibertytown, MD
Salt	permit. Pag Department Importent: any injury conce.		21. Signature of Funer Service Licenses		22. Name and Address of Facility Th		
	402 8 Q		22a Part Fater and disease or complic				Approximate
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	0, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):			
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Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	by Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
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ž	Physicien: this certific ral director,	2	1 ☐ Yes 2 No	espital: 1 Impatient 2 ER/Outpati		ome 5 Residence	
	te te	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	ijury occurred
Division	el or Attendir s after death. el Director: Al	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
	Hospit 4 hour Funer ely fills	edical (29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	cian: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the To the To the Complet	Me	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)
			*Kachel de	MD MD	AU4176435	S15888 1	May 28 2005
	17		30. Name and address of person who cor	npleted cause of death (Item 23a) (Typ		Ralbana	1 MD 21201
	10		31 Date filed (Month, Day, Year)	32. Engistrar's Signature	CITE SCIECT	TO THE	, 100

Registrar

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		1	1 - State of Maryland / Den 1 - State of Maryland / Den 23e per Dr., C849, 12	partment of Health and Me Of 105dhb Prifficate of Death	ental Hygien	2005 19674
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}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
		ш	Shady Grove Adventist Hospital	Rockville		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
ш	Director		220-26-4662		11/02/193	4 Pennsylvania
	and *	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
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	ours after death with the Marylan raf, or Items 23a or 28a-f show Examiner mat be notified at	Director	MD Montgomery Germanto	10f. Zip Code	100.0	Ditizen of What Country?
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	eath	Funeral	19941 Appledowre Circle 11. Marital Status 12. Was Decedent Ever in U.S. 15.	Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R		14. Race - American Indian,
	ter d	F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Rican, etc.)	Black, White, etc.
93	urs a	by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: White
Ò	72 hours after death with the Maryland "netural", or Items 23a or 28a-f show dical Examiner must be notified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation	16b.	Kind of Business/Industry
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ore	S S S S		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	sposition (Name of Darematory or other place)	ate 20c.	Location - City or Town, State
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			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		~	Approximate Interval Between Onset and Death
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	/Medical		resulting in death) Due to (or as a consequence of):		1	
	Examiner	l. I	Sequentially list conditions. b. Cos polymore	nale		years
	₽ #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ate be executed only sician and the burial-transit	am	that initiated events C.			
90,	e exection significant		resulting in death) Last Due to (or as a consequence of):			
8760,	ate b	dlca	d			
9	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23c, If yes, outcome of pregnancy			
Вох	aath certif attending for use as	lan/	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	the a	/sic	1 Pres 2 No 9 Unknown	5 Other (specify)		
P.0	that the d		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
S,	ires that signed t	by	ANEMIA		1 ▼ Yes	2 No 3 Probably 4 Tunknown
Vital Records,	w requir been si should	Completed by				
ec	e law has b	npl	Dialectes Mellity		24a. Was an autopsy performed:	24b. Were autopsy findings available prior to completion of cause of death?
H	The cate I	Co			1 Yes 2	No 1 Yes 2 No
/ita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death	(Check only one)	
of	Physicien: this certificatal director, p	2	1 Yes 2 No 1 Sunpatient 2 Er/Outpa		ne 5 Residence 28d. Describe how in	6 □Other (Specify)
ū	After Unera	lon:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Natural 1 Panding 28b. Tim	y Work?	28d. Describe flow iii	ijury occurred
sio	tend feath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury At home farm		Off Location (Street	and Number or Rural Route Number,
Division	or Attending after death. Director: After in by the fune	Certification;	4 Homicide 4 Homicide 4 Homicide 4 Successful At home, farm, building, etc. (Specify)	street, ractory, office	City or Town, St	
	urs a		CO. Carties (Decatitude Physician Table heat of an Isoculaded	eath accurred at the time date and place.	and due to the equip	(c) and manner as stated
	Host 14 ho Fun fely f	edical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, d (Check only one) Medical Examiner: On the basis of examination and/o and manner stated.			
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
	T W C		Some and the state of the state	D53317	1	ay 23 2005
	12				11 17	1 - 2 - 2 - 2
			30. Name and address of person who completed cause of death (Hem 23a) (Ty Jos Eitt Ball 1622 frederick Rux	permiti	Wus mi	2.0477
		040	Joseph Ball 1622 tederick Rux 31. Date filed (Month, Day, Year) 31. Registrar's Signature	1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		0711
•	St Regist	ate rar	31. Date filed (Month, Day Year) MAY 2 7 2005 Registrar's Signature	saile)		
		- 4	Marine 1			

JET 05-03598 Jose G. Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend I per meo 8844 6-17-05 vt

G	. Moral	.es	For State Registrar	State of Ma			artment of F tificate of		nd Mentai Hy	rgiene Reg. No.	005	19675
	Physici	a n	1. Decedent's Name (First, Middle, La	st) Jose Ga	abriel	Mo	rales		2. Date of De Month	eath	Vone	3. Time of Death
	Physici /Medic			oriel Mc	rales				May 2	25 ^{Day} 200	5 Year	5:50 A M
	Examin	er	4a. Facility Name (If not institution, give		_		4b. City, Town, o		Death		nty of Death	
			University Blvd			16 al I	Silver		Heal		gomery	
	Funeral Director		5. Social Security Number 6. S	M 2□F	(In yrs. last bin	rnoay) Yrs.	Months Days		Min. 8. Date of Bi	rth ay, Year) 9/1933	9. Birth Cou	place (State or Foreign intry) Salvador
			Usual Residence of Decedent		7 2				3/13	7/1933	151	Salvador
	how		10a. State 10b. County		10c. City, Town							10d. Inside City Limits
	Ba-f s	cto	MD Montg	omery	Silv	er	Spring					1 ☐ Yes 2 🔀 No
	with the	Director	10e. Street and Number	3	102		10f. Zip Code	0.01		10g. Citizen		-
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. A dother than "netural", or items 23a or 28a-f show about, the Modical Exartirer must be notified at	Funeral	8703 Arliss S	-		140.1		901			Salva	
	ter d	Ş	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2X N		13. 1	Was Decedent of H f Yes, specify Cuba	tispanic Origir an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	0- 14. F	Race - Ameri Black, White,	can Indian, , etc.
2	urs a	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Yes 2□No		Salvador	Spe	ocity: Wh	nite
2-003d	filed within 72 hours after Hygiene. ither than "netural", or Ite snt, It e Medical Exertire	Completed	15. Decedent's E (Specify only highest gr	ducation	16a.	Deced	lent's Usual Occup	ation			f Business/Ir	ndustry
V	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done OO NOT use retired		i working			
Z	fled w flygier her tl ht, th		17. Father's Name (First, Middle, Last	0		Un	employe			noi		
	ntal F ed of	Be		,					Name (First, Middle		name)	
<u> </u>	2 should be and Menta Is marked aumatic ev	2	Jesus Morales 19a. Informant's Name/Relationship	Tyne Print)	19h	Mailin	n Address (Street		icitas V or Rumal Route Numb		em State 7	- 0000 0 0 4
20	ulth ar ath ar 27 is r trau		Dionigio A.Rod		phew	8	703 Arl	iss S	t.Apt.10	3 Sil	ver S	pring,Md
ā,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury geather traumatic once.	1	20a. Method of Disposition		20b. Place of	Dispo	sition (Name of natory or other place	20)	Date	20c. Locatio	on - City or To	own, State
Ē	Pages ment of ent: If it	100	1 XBurial 2 □Cremation 3 □ 14 □Donation 5 □Other (Special	Removal from State			io Caba		5/01/05	Sens	unter	peque,
Daitimor	permit. Departm Importe any inju		21. Signatu of Funeral Service ic	ns (6)	•	32	Name and Addre	ss of Eacility	LDI FUNE			
<u> </u>	89 = 9		Willy Que			9	241 Col	umbia	Blvd.Si	lver S	Sprin	a,Md
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do re.	ot ent	er the mode of dyin	ng, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
	nysician	K V	Immediate Cause (Final disease or condition	a. MUIT	ble In	1	ries					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	off.						
		-6	Sequentially list conditions, if any leading to immediate	b. Due to (or as a	a consequence o	nfi:						
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			,-						
2	tificate be executed g physician and as the burial-transit	Еха	that initiated events resulting in death) Last	C. Due to (or as a	a consequence	of):						
00/00	te be ysicia ne bur	edicai		_ d								
	rtifica ng ph	400	IE EEMALE.									
200	ath ce ttendi or use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3□	Ectopic pregnancy	,			Date of delive	
5	the atten	Physician/A	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆	Other (specify)			'	Month	Day Year
7	w requires that the death cer been signed by the attendin should be detached for use	Ph)	Part II. Other significant conditions	contributing to death bu	ıt not resultina in	the ur	deriving cause gry	en in Part I	23e Did t	obacco use co	ontribute to t	he cause of death?
Ď	uires sign	d by		,	3		isony ing sauto giv	5.7 ATT 2.11.	1 🗆	~ -		pably 4 🗀 Unknown
Spids	law req as beer 2 shou	ompieted							24a. Was			aney findings available
i L	0 2 0	omp		•					auto perfo	psy ormed?	prior to co death?	psy findings available mpletion of cause of
	ician: Th certificate rector, pag	e C	25. Was case referred to medical					26 Place of	Death (Check only of	2 No	1/2 Yes	2 No
>	dis y	To B	examiner? 1X Yes 2 □ No	Hospital: 1 Inpatie	nt 2 🗆 ER/Out	patien	3 DOA Oth	05	ing Home 5 ☐ Resi	1	ther (Specif	y Scene
5	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day		ime of	28c. Injun	y at	28d. Describe	how injury occ	urred	
202	Attending it death. ector: After by the fune	cati	2 Accident investigatio 3 Suicide 6 Could not b	11146	00-10		AM 1□	Yes 2√No	Pedest	ricun Sh	wih b	y tuch
\leq	l or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide determined		. (Эреспу)		et, factory, office		28f. Location (Street and Nui vn. State)	mber or Rura	I Route Number,
_	phtal		29a. Certifier 1 ☐ Certifying Pl	Nysician: To the best of	Stree		conversed at the time	no data and s	1 Rd , 51	Ver Son	ina M	1D. '
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only one) Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and	/or inv	estigation, in my o	pinion, death	occurred at the time,	date and place	e, and due to	tated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date sign	ned (Month,	Day, Year)
			1 Jasho?	Tree O	des		OCM	Œ		May 2	6 200)5
	,		30. Name and address of person who	completed cause of de	eath (Item 23a) (Туре,				J		
		l.	Tasha Z. G	reenbero	M.D		111 Per	ın Stre	et Balti	more, M	lary1a	nd 21201

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
MAY 2 7 2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY* 21,2005 **Physician** Year JAMES ALLEN McCOWN 11:45A™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HERITAGE HARBOR HEALTH & REHAB. ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year), FEB. 16, 1943 **Funeral** 9. Birthplace (State or Foreign 1**⅓**M 2□F Months Days Hours MARYLAND 217 40 2480 62 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND ANNE ARUNDEL CROWNSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö with 1090 GENERALS HIGHWAY 21032 UNITED STATES Completed by Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed withIn 72 hours after ^{™Yes} ^{2□No}1961–63 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE 3 ☐ Widowed 4 M Divorced "natural", Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 Is marked other that any injury or other traumatic event, That ODG. MAINTENANCE MECHANIC HEATING & AC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JACK TWITTY ELEANOR ELIZABETH HOMBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PAMELA D. ALTON (SISTER) 1090 GENERALS HIGHWAY CROWNSVILLE,MD. 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KALAS CREMATORY 05-23-05 EDGEWATER MD. 21. Signature of B 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician acuan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE: for use If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vnknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 🗌 Yes 2 **N**0 Certification: To filled in by the funeral Manner of Deat 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After ! Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the ţ 29c. License number 29b. Signaty 20 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.D. AVE #231 ANNAPOUS, MD 600 PIDEELY State MAY 2 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 005

		1 - For State Registrar	State of Marylar	nd / Depa	artment of H	lealth and Mo Death		ne 005	19677
Physic /Med Exam	ical iner	1. Decedent's Name (First, Middle, Last) Dar bara 4a. Facility Name (If not institution, give str Atlata Cene 5. Social Security Number 6. Sex	ral Hospi	tal	4b. City, Town, or Section	r Location of Death	2. Date of Death Month 5 - 2	Day Year 7-2005 4c. County of Dea	4:00 PM
Funera Directo			7. Age (In yrs. 70	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yo 10/16/34	ear) 9. Bi	rthplace (State or Foreign ountry) "yland
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or items 23e or 28e-1 show umatic event, the Madical Examinar must be notilised at	rector	10a. State 10b. County Maryland Worceste 10e. Street and Number		ty, Town or Lo	ocation		100	. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 No
5-0036 72 hours after death with the Maryla natural; or items 23s or 28s-1 shouldest Examinar must be notified at	Funeral Director	5 Hemlock Lane 11. Marital Status 1 □ Never Married 2 Married 12	. Was Decedent Ever in U Armed Forces? 1 □ Yes 2√7 No	1	21811 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spec In, Mexican, Puerto F	·	J.S.A. 14. Race - Am Black, Whi	erican Indian,
15-0036 72 hours aft "natural", or	۾	3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of	1 Yes No If Yes, Give Year or Dates: tion completed)	16a. Deced	1 Yes 2X No	durina most of workin	16	Specify: Wh	
d 2121 filed within Hygiene. ther than '	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	Cotlege (1-4or 5+)	life. I	maker	18. Mother's Name	Fa	amily Car	egiver
aryland should be nd Mental marked o	To Be	Samuel Hidey 19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir		Thelma C	rummit	•	Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or any injury or other traumatic event, the Neglical Examples on one any inconse		Stanley Howard Mas 20a. Method of Disposition 1 □ Burial 2 💢 Cremation 3 □ Rer	20b. F	5 Her	mlock Lar sition (Name of natory or other place	ne Berlin		1811 c. Location - City or	
Baltim permit. Par Departmen Important: any injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Fune at Service Licensee		22	. Name and Addres	rem. 5/28/ ss of Facility age Funer		ankford, 108 Willia	am St.
Physician /Medica Examiner		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	tions that caused the deat cause on each line. Lnd Sta Due to (or as a consequence)	n. Do not ent	er the mode of dying	g, such as cardiac or	respiratory arrest	Der IIII,	Approximate Interval Between Onset and Death
760, be executed sician and burial-transit	Examiner	Sequentially list conditions, it any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
68760, tificate be ex	edicai	d							
D 16/16/1/934 D 5/2/2005 ords, P.O. Box 68760, requires that the death certificate be executed even signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	l death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
DOD 5/47/ ecords, P law requires that as been signed b	þ	Part II. Other significant conditions contri	buting to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac		o the cause of death?
19 00 in Rec	Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
On of other this tuneral distribution	ation: To Be	1 195 2 NO	pital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	26. Place of Death and 4 Nursing Hom at 28 Yes 2 No			icity)
INIS	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stro y)	eet, factory, office	28	8f. Location (Stree City or Town, S	t and Number or R itate)	ural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled it.	Medical	one)	ian: To the best of my knor: On the basis of examina and manner stated.	ition and/or inv	estigation, in my op	pinion, death occurred	d at the time, date	and place, and due	to the cause(s)
Too Too	-	29b. Signature and title of certifier 30. Name and address of person who comp KRISTINE M. GRI	Sugar	mo	29c. License	006795	(DE) 29d.	Date signed (Mont	n. Uay, Year)
C. H. 10		30. Name and address of person who comp	Fred cause of eath (Item	п 23а) (Туре, 2001—1	Print) PUASTAL	HIGHLIA	Y FENU	ICK ISU	ANDDE PRIV

State Registrar

31. Date filed (Month, Day, Year)

MAY 3 1 2005

	1 - For State Registrar	State of Maryland / Dep	partment of Health and Me <i>rtificate of Death</i>	fental Hygiene Reg. No.a	
Physician	Decedent's Name (First, Middle, MICHAEL GEO	Last)		2. Date of Death Amonth Day JUNE 6, 20	3. Time of Death 05 Year 8: 20P. M
/Medical Examiner	4a. Facility Name (If not institution, 63 HIGHLAND	give street and number)	4b. City, Town, or Location of Death INDIAN HEAD	4c. (County of Death ARLES
Funeral Director		Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Ct • 20 , 196	9. Birthplace (State or Foreign PA •
the Maryland 28a-f show notified at	Usual Residence of Decedent 10a. State MARYLAND CHAI	10c. City, Town or IND	ocation IAN HEAD		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
h with the . 23a or 28a at be notif	10e. Street and Number 63 HIGHLAND	PLACE	10f. Zip Code 20640		en of What Country?
72 hours after death with the Maryland 72 hours after death with the Maryland 72 hours or leems 23a or 28a-f show cited Examinar must be notified at leted by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2☐ No Specify:	Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: WHITE
30 -	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education 16a. Dec (Gingrade completed) (Gingrade (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ring	d of Business/Industry
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tre M. To Be Comp	17. Fathers Name (First, Middle, L.	ist)		GLAS e (First, Middle, Maiden S ARET NAHAY	·
ind 2 should be file alth and Mental Hy 27 is marked oth ar traumatic event To Be (19a. Informant's Name/Relationshi		iling Address (Street and Number or Rur HIGHLAND PL. INI	al Route Number, City or DIAN HEAD,	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific Properties)	ocity) METROPOLI	ematory or other place) IAN CREMATORY 6.	-7-05 ALEX	ation - City or Town, State
permit. Depart Import any inj	21. Signature of Funeral Service Li	censee MOO479 complications that caused the death. Do not e	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MD. 20		Approximate
executed In and in and instruction in and Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	the state of the s	SINAMASA	Interval Between Onset and Death
ath certificate be attending physicis or use as the buse and the buse			□Ectopi¢ pregnancy □ Other (specify)'	2:	3d. Date of delivery Month Day Year
be of	Fait II. Other significant condition	s contributing to death but not resulting in the	underlying cause given in Part I.		e contribute to the cause of death?
The law requires t cate has been signe page 2 should be Completed by		******		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ng Phyaician fler this certific neral director on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursing Ho	th (Check only orle) ome 54 Residence 6 28d. Describe how injury	
To the Hospital or Attending P within 24 hours after death or on the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could no determin		street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
the Hospii in 24 hour the Funer pletely fill ledical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my knowledge, de xaminer: On the basis of examination and/or and manner stated.		red at the time, date and p	place, and due to the cause(s)
To the complete of the complet	29b. Signature and title of certifier		29c. License number DO0 3 3 4 2 (signed (Month, Day, Year)
State Registrar	30. Name and address of person was B.LARRY JENK 31. Date filed (Month, Day, Year) JUN 1 0	32. Pegistrar's Signature	ANGE AVE. LA PL	ATA,MD. 20	0646

		•	For State	State of Ma	ryland / Depa <i>Cer</i>	rtificate of I				
			Registrar 1. Decedent's Name (First, Middle, Las.	")		timodio or i	3	2. Date of Death	g. No.	3 Time of Death
	Physicia	an	BILL		MINTER			JUN 6	Day Year	1:02 PMW
	/Medic		4a. Fecility Name (If not institution, give		HILITER	4b. City, Town, or	Location of Death		4c. County of Deat	
	Examin	er	NATIONAL NAVAL		ENTER		HESDA		MONTGO	MERY
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	hplace (State or Foreign
	Director		443-20-2212	™ 2□F	78 Yrs.	Months Days	Hours Min.	July 13,		ahoma
		į	Usual Residence of Decedent							
	ylan		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	a-f-	cto	Virginia Fauqui	er	Warrento	n				1 ☐ Yes 2 🖺 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	th wi	ai	8385 James Madison	n Highway		2018	б		United Sta	tes
	dea	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp. Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whit	
9	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow ilisal Ezamimar mual be muililed at	<u> </u>	1 ☐ Never Married 2 € Married	1X1Yes 2∏N	0	1 ☐ Yes 2100 XNo	Specity:		Specify:	white
Ö	ural',	d by	3 Widowed 4 Divorced		0/48-8/84			1.		
21215-0036	"nat	Completed	15. Decedent's Ed (Specify only highest grad		16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of world is	king	6b. Kind of Business/	Industry
12	within ene. than "	E .	Elementary/Secondary (0-12)	College (1-4or 5-	-)	neral	'/	ŀ	United Sta	tes Air Ford
22	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "natural", or iteme 23a or 28a-f show other then "natural", or iteme 23a or 28a-f show event, the Medical Examinat must be notified at		17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M		
Maryland	ld be ental ked o	o Be	Henry Hargis Mint	er			Eva Jo B	Sutton		
$\overline{\leq}$	2 should be and Mental Is marked aumatic ev	၉	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street			City or Town, State, 2	Zip Code)
Z	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		Marion P. Minter-			James Mad			T7 A O	0186
a)	s 1 and 2 of Health a Item 27 is other trai		20a. Method of Disposition	wile	20b. Place of Dispo	sition (Name of			0c. Location - City or	Town, State
altimore,	Pages nent of ant: If It ary or o		1 □XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		Arlington	matory`or other plac National		28,2005	Arlington	, Virginia
量	artme ertme ortan injur		21. Signature of Funeral Service Licen		22	2. Name and Addres				20186
Ba	permit. Pages Depertment of Important: If II any injury or once.		Kalleer	K. G	M	loser Fund	eral Home	, 233 Br	oadview Av	e, Warrenton
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			DV DTCEAC	D.			Onset and Death
	/Medical		resulting in death)		NARY ARTEI consequence of):	XI DISEAS	E			
	Examiner		Conventially list annulitions	h						
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
	cutec nd ransi	Examiner	that initiated events	c. Due to (or as a consequence of):						
oʻ	e exe ian a urial-	EX	resulting in death) Last	Due to (or as a	consequence of):					
68760,	ficate be executed physician and is the burial-transit	edicai		d						
_		Med	IF FEMALE:						1	
Вох	death certif e attending od for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth		Ectopic pregnancy	,		23d. Date of del	ivery Day Year
	e dea	sici	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			Mona	bay roa
P.0	that the de led by the a	Phy	Part II. Other significant conditions or	antido de deste bu	tt	adathia anns an	an in Bort I	22a Did tob	acco use contribute to	the cause of death?
ŝ	ires tha signed	þ	rait ii. Other significant conditions of	annibuting to death bu	t not resulting in the a	inderlying cause giv	enin Faiti.		37	robably 4 Unknown
orc	taw requires as been sign 2 should be	ted						1 (0.	20140 0011	- Gridiomi
Vital Records,	e law has b	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	The ate pag	Co						perform 1 Tes 2		2 No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					th (Check only one)	
of	Physic this c	70	1 ☐ Yes 2 X No	100	nt 2 ER/Outpatier		4 🗀 Nursing n		nce 6 Other (Spe	city)
	ter ite	on:	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o Injury	Wor	k?	28d. Describe how	winjury occurred	
Sio	Attending or death. ector: Afte by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	-			Yes 2 □No	ODE Laureign (Car		and Double At the
Division	I or Attendir after death. I Director: Af d in by the fu	ertification:	4 Homicide determined	building, etc	ry - At home, farm, str . (Specify)	reet, factory, office		City or Town,	eet and Number or Ru State)	irai noute Number,
	Hospital 24 hours a Funeral I	O	29a. Certifier 1 € Certifying Ph	ysicien: To the best o	f my knowledge deat	h occurred at the tir	ne, date and place	and due to the ca	use(s) and manner as	stated
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical		niner: On the basis of and manner sta	examination and/or in					
	within 2 To the	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
	->-0		1/hans ni	2	nD	326	51 (WI)	-	UNE OT	20-
	1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print) N Δ	TTONAT. N		CAL CENTE	
	13		TAMES D DIMME		JSN			D 20889-5		
	Sta	te	31. Date filed (Month, Day, Year)	20 Annietes	de Cienatura					
	Registr	ar	JON T 0 5	005 See	J. J. A.	SALL!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 2, **Physician** Month 2005 Joseph Benton Martin 4:20P M /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
June 5, 1945 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F Days Hours Months Min. Mary land Director 216-44-1923 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Havre de Grace Yes 2 No Harford Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Green Street 21078 USA death v Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itan any injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify þ 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) country club laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laura Ruth Hinder Davie Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 267, Hardeeville, SC 29927 Doris J. Wise (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State 6/8/2005 4 □ Donation 5 □ Other (Specify) RA Ferris & Company West Chester, PA 21. Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or compfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MASSIVE ASCITIS SECONDARY TO Sequentially list conditions, Due to (or as a consequence or): Examiner dany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit LIVER FAILURE and resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, requires that the death certificate be THROMBOCYTOPENIA Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death
9☐ Unknown Month Year Day 5 Cher (specify) ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2X No 1 ☐ Yes of or Attanding Physician: after death. Director: After this certification director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3□ DOA 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 THomicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 D 41412

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JUN 1 0 2005



			1 - State of Maryland / Dep	artment of Health and Martificate of Death	lental Hygiene Reg. No.	005 968
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ROBERTA A • MILLER		June 5,	2005 3. Time of Death 6:00A м
	Examin		4a. Facility Name (If not institution, give street and number) Eagle View	4b. City, Town, or Location of Death Whiteford		County of Death arford
	Funeral Director		5. Social Security Number 162-05-9152 Usual Residence of Decedent 6. Sex 1 M 2534 7. Age (In yrs. last birthda) 91 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 3/14/1914	9. Birthplace (State or Foreign Country) Pennsylvania
	f show	ō	10a. State 10b. County 10c. City, Town or	ocation hiteford		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the h	Director	10e. Street and Number 4403 Flintville Road	10f. Zip Code 21160	10g. Citiz	ten of What Country?
36	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show dical Examiner must be nufficed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- 1 Rican, etc.)	4. Race - American Indian, Black, White, etc. SpecifyWhite
21215-0036	ss 1 and 2 should be filed within of Health and Mental Hygiene. I item 27 is marked other then "r other treumetic event, the Mar	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	d of Business/Industry
		To Be Cor	12 H. 17. Father's Name (First, Middle, Last) Albert Morris		e (First, Middle, Maiden S h Glackin	Own Home Sumame)
Maryland		ĭ		ing Address (Street and Number or Run Woodbine Road	al Route Number, City or	· · · · · · · · · · · · · · · · · · ·
Baltimore, I			20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposered Competery, cr	The state of the s	Date 20c. Loc	eation - City or Town, State esville, MD
Balti	permit. Pag Dep.rtment Importent: I any injury o		21. Signatural Funeral Service Licensee	2. Name and Address of Facility Harkins Funeral Home, I		
8760, <	Physician /Medical Examiner bullistical and sthe pnilal-transit	dical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	FROTIC CARDIC	VASCULADE 15E	Approximate Approximate Interval Between Onset and Death ONER SHE OVER SHE OVER SHE OVER SHE
P.O. Box 6	law requires that the death certificate as been signed by the attending phys 2 should be detached tor use as the	Physician/Medl		□Ectopic pregnancy □ Other (specify)	23	3d. Date of delivery Month Day Year
	w requires that the bear signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the CONGES TO VE HEART FOR		23e. Did tobacco us 1 Yes 2	se contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available
al Re	The ate h	Completed			autopsy performed? 1 ☐ Yes 2 ♠ No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Division of Vital Records,	if or Attending Physicien: The after death. Director: Atter this certificate in by the funeral director, pag	ertification; To Be	25. Was case referred to medical examiner? 1	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	n (Check only one) me 5 ☐ Residence 6 28d. Describe how injury 28f. Location (Street and City or Town, State)	
_	Hospite 4 hours Funerel ely tilled	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, developed to the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause(s) a red at the time, date and p	and manner as stated. place, and due to the cause(s)
)	To the within 2-	Me	29b. Signature and title of certifier Perfect. Values 1	29c. License number DØØ1638		e 6, 2005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type Perfecto C. Valarao, 1716 Har	-	ton,MD	-
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	norte .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mollie Noah MAY 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death LAPLATA

Jer 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Nov. 25, 1 CHARLES CIVISTA MEDICAL CENTER If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☐ M 2 💢 F 1931 Washington, 73 577-40-0002 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No MD Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20601 3047-A October Place Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🂢 No Specify: Specify: White 3 Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nora Frances McHale Walter Lee Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget L. Wolfe - Daughter 11470 Airport Rd., Waynesboro, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 05-27-2005 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home P.O. Box 156, Waldorf, MD M00053 Yout M Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) HEMORRHAGE Due to (or as a consequence of)

Physician /Medical Examiner

burial-transit

attanding physician for usa as tha buria

signad by the a

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician:

aftar daath.

within 24 hours a

Examine

Completed by Physician/Medical

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Certification:

Medical

State

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

ortant: If itam 27 is marked other than "natural", or items 23a or 28e-1 show injury or other traumatic evant. The Medical Examiner must be notified at

gas 1 and 2 should be filad and Health and Mantal Hygie

Dapartment of Hear Important: If item

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide 4 \ Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🖺 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

certifier 29b. Signature and title

29c. License number D-57708

29d. Date signed (Month, Day, Year) 5-25-05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abbas A. Omais, liled (Month, Day, Year) Cenna Medical Center, 7-C Post Office Rd., Waldorf, MD 20602

MAY 2 7 2005 Mereva

MP 10

				partment of Health and Mertificate of Death	lental Hygie	After alle and a
	Physici		Decedent's Name (First, Middle, Last) Thomas John O'Hara		2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 19124 Long Meadow Road	4b. City, Town, or Location of Death Hagerstown	5	4c. County of Death Washington
	Funeral Director		5. Social Security Number 6. Sex 181-36-0706 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Ye Jan. 3,	9. Birthplace (State or Foreign Country)
	Maryland e-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Washington Hagers			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 28	al Director	10e. Street and Number 19124 Long Meadow Road	10f. Zip Code 21742		Citizen of What Country?
920	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or terms 23a or 28e-f ahow avent, the Medical Evanfrer must be rodified at	by Funeral	1 Never Married 2 Married 1 XYes 2 No	3. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 1 No Specify: 1 ☐ Yes 2 1 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
Maryland 21215-0036	e filed within 72 ho il Hygiene. other than "natur vant, I're Medical	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work i. DO NOT use retired) iness admn.	ing 16t	o. Kind of Business/Industry finance
/land	2 should be filed and Mental Hygid is marked other aumatic avent, II.	To Be C	17. Father's Name (First, Middle, Last) Joseph William O'Hara		e (First, Middle, Maid Cille I	den Sumame) Deets
	l and lealth im 27 her ti		Mary A. Garrity - sister 106	romatoni or other piece)	ar, New Je	
Baltimore,	permit. Pages 'Department of the Important: If ite eny injury or ot once.		*4 □ Donation 5 □ Other (Specify) Hagerst 21. Signature of Fineral Service Licensee	own Crematory 20	linnich Fu	agerstown, Maryland neral Home stown, Maryland 21740
8760,	requires that the death certificate be executed with the attending physician and required by the attending physician and required by the attending physician and required for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not each shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease of high that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
.O. Box 6	that the death certific ed by the attending p detached for use as t	Physician/Med		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	w requires that the bean signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2 No 32 Probably 4 Unknown
al Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed 1 Yes 2	
Division of Vital	ding Phys n. After this funeral dir	Certification; To Be	25. Was case referred to medical examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury - At home, farm, so building, etc. (Specify)	of 28c Injury at Work? M 1 □ Yes 2 □ No	me 5 Residence 28d. Describe how in	t and Number or Rural Route Number.
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
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		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)		aryland / Depa <i>Cei</i>	artment of H			Reg. No. 2	005	1958
Physi		Eugene Edward Poli					Month May	Day 25,	2005	3. Time of Death 5:27 p M
/Meć Exam		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of De			unty of Death	1 E
		Millenium Health & Rehab. Ctr. Glen Burnie								Arundel
Funera Directo		5. Social Security Number 6. Sex 210–20–3998	7. Ag	e (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		192 192	9. Birthp	place (State or Foreign PA
Maryland s-f show	tor	10a. State 10b. County MD Anne Aru	ndel	10c. City, Town or Lo	Severn				1	0d. Inside City Limits 1 ☐ Yes 2X No
ith the	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	-
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within 72 hours after death with the Maryland ene. then "naturel; or items 23a or 28a-f show its Mudical Everiting must be retilified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1	1946− 1948	f Yes, specify Cuba 1 ☐ Yes 2 [X] No	Specify:	(Specify Yes or No- erto Rican, etc.)		Black, White,	
INIGITY GILLO KILLIDOOOO 4.2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 17 is marked other then "naturel; or items 23a or 28a-f show treumatic event, the Mudical Evertings must be rutified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired Teacher	ation fu <i>ring most of</i> w)	vorking		of Business/Industry e Arundel County	
aryidilla ZIZ should be filed within and Mental Hygiene. s marked other then umatic event, IEEM	To Be C	17. Father's Name (First, Middle, Last) Walter Polm					lame (First, Middle, VS Evans	Maiden Sun	пате)	
E, Mally t and 2 sho Health and I tem 27 is ma		19a. Informant's Name/Relationship (Type Margaret Jane Poli			-		Rural Route Numbe Severn, N	-	wn, State, Zip 144	Code)
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permit. Departn Imports any inju		21. Signature of Funeral Service License	Hlen				A. Sever Hwy, Seve			
_ f nysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each	the death. Do not ent ne.	er the mode of dying	g, such as card	iac or respiratory ar	rest,		Approximate Interval Between Onset and Death
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ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):						
The law requires that the death certificate be executed the has been signed by the attending physician and laye 2 should be detached for use as the burial-transit	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ery Day Year
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	tate	30. Name and address person who co	Siethu &	leath (Item 23a) (Type, LOS Cround ar's Signature	Highway	South u	vest Cler	Bun	nie N	1021061
Regis		MAY 3 1 2	005	m & A	Soul !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item #8 State RegistrarWCHD/SH 6/2/2005 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** ZTAM Pau1 Joseph PETERSON, Jr. 2005 28 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hagersto Washington Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birtto 128 / 51

Months Days Hours Min. (Month, Day) 128 / 51 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2 ☐ F 53 220-52-1890 Director 195∦ Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examinar must be notified at Maryland Washington Hagerstown 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1531 Crest View Avenue 21740 U.S.A. Items 23a death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status If Yes, specify Cuba 1 X2Yes 2 No If Yes, specify Cuba If Yes, specify Cuba If Yes, specify Cuba If Yes, specify Cuba 1 Yes 2 No Year or Dates: Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced "naturat" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than. $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 0-12 \end{array}$ College (1-4or 5+) breakman railroad Pages 1 and 2 should be filed nent of Health and Mental Hygisht: If item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul Joseph Peterson, Sr. Rebecca Margaret Semler 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Belinda Peterson - wife 1531 Crest View Avenue, Hagerstown, Maryland 21740 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State June 1 1

Burial 2

Cremation 3

Removal from State Department of Important: If any injury or once. Cedar Lawn Memorial 200´5 Hagerstown, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address A Sility Minnich Funeral Home East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final chronic 035 1~uc/12 Physician resulting in death) /Medical Due to (or as a consequence of): Examiner p, bes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit abe 1 that initiated events sician and resulting in death) Last Due to (or as a consequence of) Box 68760. Aprica 66 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 2 No certificate 1 Yes filled in by the funeral director, Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending 1 Tes 2 No investigation death. 2 Accident after death 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a. Certifier 1🗂 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 1 2005

FARID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARID MUNSHED MD 32. Registrar's Signature

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amend item#23a, permi, 6844, 6/13/02 11 State of Maryland / Department of Health and Mental Hygiene 1- State Registrar MEND#23aPT1/2perMD5/27/05, PM, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Jerry L. Pearce 2005 2:10 P. May 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Olney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**⊠** M 2□ F Yrs. 85 Director 579-18-8394 May 1, Washington, D.C. Usual Residence of Decedent 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Exandrational be multified at any injury or other traumatic event, the Medical Exandrational be multified at once. 10a. State 10b. County 10d. Inside City Limits Potomac 1XYes 2 □ No Maryland Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9405 Falls Bridge Lane 20854 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW TT Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify: 3 ₩idowed 4 Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Calligrapher Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robinson Pearce Bessie Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9405 Falls Bridge Lane, Potomac,MD 20854 Kathleen Pearce/ Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Georgetown University May 23
Modical Center 2005 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. ` 4 Donation 5 ☐ Other (Specify) ature of neral Service License 22. Name and Address of Facility Columbia Mortuary Services, P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Uremia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):

Arteriosclerotic Heart Disease Arterioselerete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 ☐ Yes referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home Hospital: 2 No 1 patient 2 1 Yes 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 ritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: in 24 hours. The Funerel Directory filled in within 2 To the I

attending physician and for use as the burial-tran

certificate has been signed rector, page 2 should be det

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Medical

with the Maryland

Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year) 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) 7-513

PARIFIC

and manner stated

32.

065288

29c. License number

29d. Date signed (Month, Day, Year)

NEW HAMPSHIKE AVB

2091

Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [5] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:05 A M Carole Gregg Perlich May 23. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5130 Bradley Blvd. Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2 🖾 F 87 578-62-3962 Director July 8, 0k1ahoma Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or flems 23s or 28s-f show any injury or other traumatic event, the Medical Event intermets to notified at once. 1X Yes 2 No Director None Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 33rd Street, N.W. 20007 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White If Yes, Give Year or Dates: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jacob Rae Gregg Laura Beagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5130 Bradley Blvd., Chevy Chase, Md. 20815 Julie Bru/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 25 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2005 Alexandria, Va. 21. Signature of Figneral Solvio 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Stroke 2 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 X No Hospitel or Attending Phyaician: 24 hours after death. Funerel Diractor: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours a 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 24, 2005 D0057896 30. Name and address of person who com eleted cause of death (Item 23a) (Type, Print) David W. Hirshfield, MD, 31. Date filed (Month, Day, Ye MAY 2 10215 Fernwood Road, #100, Bethesda, Md. 20817 3 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 5:30 A G-TORIA 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie
| If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Prince Georges 3900 Croydon Lane 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 👿 F Months Washington, Director 83 09/03/1921 DC 578-18-6475 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County is marked other than "netural", or Itams 23e or 28a-f show traumatic avant, the Medical Exercise; must be notified at 1 TYes 2 □ No Directo Maryland | Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If itam 27 is marked other than "netural", or Itams 23e or? 3900 Croydon Lane 20715 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pete Bradlev Martha Alma Gosner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 is
eny injury or other trau Edward E. Prokop/ Husband 3900 Croydon Lane Bowie, MD 20715 20b. Place of Disposition (Name of cometer, crematory or other place)
Northern
Virginia Crematory 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/25/2005 | Arlington, VA ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 0/-16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastaric pancreas cancer Pnysician disease or condition resulting in death) /Medical Examiner enal cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or as a consequence of): Examine burial-transit or Attanding Physician: The law requires that the death certificate be executed that initiated events physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 month 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 page 2 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 sidence 6 Other (Specify) Hospital: 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Certification: After 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the f after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funeral Completely filled the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2003-DS3070 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Daniel A. Iehenu, M.D.,

1 H H 1 h 50 Or leans of Baltomore, M.D., Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 25

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death wonth 24, **Physician** 2005 2:55 P. M Martin Vernon Proctor, Sr. May /Medical 4a. Facility Name (If not institution, give street and number) Assisted Living 4b. City, Town, or Location of Death 4c. County of Death Examiner Hanover Anne Arundel Morningside House of Friendship If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Mar. 20,1923 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 XM 2 □ F 579-16-6009 Yrs. Maryland Director Usual Residence of Decedent Pagas 1 and 2 should ba filed within 72 hours after death with tha Maryland health and Mental Hygiene. 10d Inside City Limits 10c. City. Town or Location 10a State 10b. County ral', or Items 23e or 28a-f show Examiner number collined at 1 ☐ Yes 2 🕱 No Director Gambrills Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1275 Defense Highway 21054 USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 TWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then " Elementary/Secondary (0-12) College (1-4or 5+) Master Mechanic Automotive 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked Martin Proctor Nellia Anne Proctor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lopartment of Health at Importent: If them 27 le n any injury or other? 2342 Silver Way, Gambrills, Maryland 21054 Joseph Daniel Proctor - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 06-01-05 1 Burial 2 □ Cremation 3 □ Removal from State Lakemont Memorial Gardens Davidsonville, Md. • 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Dceases Beall Funeral Home 6512 N.W. Crain Hwy., bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician (eal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ been signed b should be deta Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dinknown Completed 24b. Were autopsy findings available prior to completion of ordise of death?

1 Yes 2 7 200 24a. Was an certificate has 2/100 1 ☐ Yes 20 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? Assisted 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Living 2 1 Yes 2 ER/Outpatient 3 DOA this 27. Manne of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and magner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 whe completed cause of death (Item 23a) (Type, Pript) 4 My 1101 10/6/11 Registrar's Signature 31. Date filed (Month, Day, Year)

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Registrar

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6	Physicia	an	1. Decedent's Name (First, Middle, Last) Dorismae R. Ragan		2. Date of Death Month May 26,	2005	3. Time of Death 12:15 PM	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 104 1st Street	4b. City, Town, or Location of Death Annapolis		4c. County of Death	1	
	Funeral Director		5. Social Security Number 579-14-1604 6. Sex 1 M 2 X F 7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 9-5-192	Year) 9. Birth Con 22 Mar	nplace (State or Foreign untry) Yland	
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Anne Arundel A	Location nnapolis			10d. Inside City Limits 1 ☐ Yes 2 No	
	with the	I Dire	10e. Street and Number 104 1st Street	10f. Zip Code 21401	10	10g. Citizen of What Country? USA		
036	s I end 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, Ite Medical Examble in met be notified.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. 1: Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:		
T.		Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) nemaker	king	6b. Kind of Business/I HOME	industry	
Maryland	S should be filed with and Mental Hygiene. Is marked other than sumatic event, Item	To Be C	17. Father's Name (First, Middle, Last) John Alexander Ryon		ne (First, Middle, M nea Hamíl			
Mary	12 shou h and N 7 Is mar traumat			illing Address (Street and Number or Rui 1st Street, Annapo			ip Code)	
Baltimore, I	0 0		20a. Method of Disposition 1 Burial 2XXCremation 3 Bemoval from State	position (Name of rematory or other place)	Date 2	20c. Location - City or Tedgewater,		
Baltii	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lipensee	22. Name and Address of Facility Geo 2973 Solomons Isla	orge P. K and Road,	alas Funer Edgewater	al Home .Md.21037	
	Physician /Medical Examiner	Ilner	23a. Part. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
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9	luires that n signed b		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to		
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Div	ital or Attend its after death rel Director: led in by the f		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town	reet and Number or Ru , State)	rai Houle (Vulliber,	
	To the Hospital within 24 hours and to the Funerel completely filled	use(s) and manner as te and place, and due	to the cause(s)					
	To t To t	Medical	29b. Signature and title of certifier	29c. License number DOD 50 2-42	29	5 26 lad	h, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type IIRS U.A. MCC/I/MONT M. 1)		Cochro	a Dr.	Annaples	
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Physician Phys	Jar											
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Physician Medical Examiner 23a. Part: Enter the disease, or or brokestones that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Respiratory Failure) 3 Months Respiratory Failure 1 Hour Terminal Aspiration Due to (or as a consequence of): Terminal Aspiration Terminal Aspiration Due to (or as a consequence of): Terminal Aspiration Due to (or as a consequence of): Terminal Aspiration Due to (or as a consequence of): Terminal Aspiration Due to (or as a consequence of): Terminal Aspirati	Jor	ages nt of 1 t: If ite		t Burial 2 ☐ Cremation 3 ☐ P	lemoval from State cemetery, crer	natory or other pla	Ind?	y 25,		•		
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Physician Medical Examiner Text Miner Te				23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between	
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The first initiated events as a consequence of): Die to (or as a consequence of):		led	ulue	r any, leading to immediate cause Enter Indenying Cause (Disease or injury	Due to (or as a consequence or):							
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25. Was case referred to medical examiner? 1	68	tificating phy as the	edic									
25. Was case referred to medical examiner? 1	.O. Box	the death cer y the attendir ched for use	ysiclan/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5		у				,	
25. Was case referred to medical examiner? 1	<u>α</u>	s that	y P	Part II. Other significant conditions con	ntributing to death but not resulting in the ur	nderlying cause gi	ven in Part I.	23e. Did t	tobacco use c	contribute to	the cause of death?	
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25. Was case referred to medical examiner? 1 Yes 2x No	Ĕ		mo.					perfo	ormed?	death?		
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28b. Linjury at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed	/ita	cien: ertifica	a	examiner?				th (Check only				
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Signature and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and due to the cause(s) and manner stated. 29b. Signature and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) May 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irnest Oser, M.D. 10301 Georgia Avenue, #304, Silver Spring, MD 20902	n	Jing After fune	lon	1 Natural 5 ☐ Pending	(Month, Day Year) 28b. Time of Injury	Wo	rk?	28d. Describe	now injury oc	curred		
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	S	Attendest dest ctor: y the	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str			28f. Location (Street and Nu	ımber or Ru	ıral Route Number.	
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				31. Date filed (Month, Day, Year) MAY 2 7 2005 Registrar's Signature								

Physici /Medio Examin		 Decedent's Name (First, Middle, Last) 				2. Date of Death		3. Time of Death		
		Joseph Stewart Roe				JUNE	3, 2005	8:35P. N		
		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or	Location of Death		4c. County of Death			
		NORTH ARUNDEL HOSPITAL	1	GLEN B	URNIE		ANNE ARUNDEL			
uneral rector		5. Social Security Number (17 V 6. Sex 18 M 2[7. Age (In yrs. last birt	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 2	8. Date of Birth (Month, Day, June 3,	9. Birt 2005	hplace (State or Foreig untry) MD		
≥ 23		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limit		
8e-f sho	ector	MD Anne Arund		Glen	Burnie			1 ☐ Yes 2 🔀 N		
23a or 2	Funeral Director	1 Clearspring Court			061		g. Citizen of What Co USA			
nd other then "neturel", or items 23a or 28e-f show event, it's Modical Examinations the confided at	d by Fune	1 Never Married 2 Married 1 ☐	s Decedent Ever in U.S. ned Forces? IYes 2X No es, Give ar or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 No Yes 2□ No		cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W			
then "netu he Mudical	Completed by	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) N/A Col	leted) 16a. lege (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired N/A	ation during most of workin l)	10	6b. Kind of Business/ N/A	Industry		
marked other then metic event, IVE M	To Be Co	17. Father's Name (First, Middle, Last) Paul Alton Roe	1		18. Mother's Name Deanna	(First, Middle, Ma	,			
es 1 and 2 s of Health ar fitem 27 is rother treu	Ì	19a. Informant's Name/Relationship (Type, Prir Paul Alton Roe/Fath		. Mailing Address (Street a				Tip Code) 1061		
		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Removal 1 □ Donation 5 □ Other (Specify)	from State cemeter	Disposition (Name of ry, crematory or other place TO Crematory		2005	Oc. Location - City or Baltimore			
Importent: I eny injury o once.		21. Sign wire of Fill gray Service Licensine Au Au Au Au Au Au Au Au Au A		Barranco & 495 Gov. r	ssons, P.A itchie Hwy	A. Severi V, Severi	na Park Fu na Park, M	neral Home D 21146		
edical miner transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury that initiated events c.	Complications The to (or as a consequence of the to (or as a c	of Prematur				Inferval Between Onset and Death		
o p	/Medicai	23b. was decedent pregnant	es, outcome of pregnancy Live birth 2	3 ☐ Ectopic pregnancy			23d. Date of deli Month	very Day Year		
attending ph for use as th	hysician	1 Type 2 No.								
ad by the attending ph detached for use as th	ed by Physician/Med	1 Yes 2 No		n the underlying cause give	en in Part I.	23e. Did toba	acco use contribute to			
ate has been signed by the attending ph page 2 should be detached for use as th		1 Yes 2 No 9 Unknown		n the underlying cause give	en in Part I.		24b. Were au prior to death?	obably 4 Unknow topsy findings availab completion of cause of		
ate has been signed by the attending ph page 2 should be detached for use as th	Be Completed by	Part II. Other significant conditions contributin 25. Was case referred to medical examiner?	g to death but not resulting in		26. Place of Death	1 Yes 24a. Was an autopsy perform 1 Yes 2(Check only one)	24b. Were au prior to death?	obably 4 Unknow topsy findings available completion of cause of 2 No		
After this certificate has been signed by the attending ph funeral director, page 2 should be detached for use as the	To Be Completed by	Part II. Other significant conditions contributin 25. Was case referred to medical examiner? 1 Yes 2 No Hospital 27. Manner of Death 1 Natural 5 Pending	g to death but not resulting in	tpatient 3□ DOA Oth	26. Place of Death 9F: 4 ☐ Nursing Hom / at 2 /?	1 Yes 24a. Was an autopsy perform 1 Yes 2(Check only one)	24b. Were au prior to code at? 1 2 2 es	obably 4 Unknow topsy findings available completion of cause of 2 No		
stor. After this certificate has been signed by the attending ph / the funeral director, page 2 should be detached for use as the	To Be Completed by	Part II. Other significant conditions contributin 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ig to death but not resulting in	tpatient 3 DOA Cthrime of 28c. Injury Work	26. Place of Death er: 4 □ Nursing Hom y at k? Yes 2 □ No	24a. Was an autopsy perform 152 Yes 2[(Check only one, ne 5 Resident 8d. Describe how	24b. Were au prior to c death? 1 Ses	obably 4 Unknow topsy findings available completion of cause of 2 No		
stor. After this certificate has been signed by the attending ph / the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by	Part II. Other significant conditions contributin 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Yatural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. 29a. Certifier (Check only 2 Medical Examiner: On	g to death but not resulting in 1 □ Inpatient 2 □ Produit Date of Injury (Month, Day Year) Place of Injury - At home, fai	tpatient 3 DOA Othining of 28c. Injury Work of 1 minury M 1 minury minury M 1 minus of the time of time of the tim	26. Place of Death BT: 4 \(\text{Nursing Hom} \) at \(\text{?} \) Yes 2 \(\text{No} \) 1e, date and place, a	1 Yes 24a. Was an autopsy perform 1 Yes 2 (Check only one, as 5 Residen 8d. Describe how 8f. Location (Stree City or Town, and due to the cau	24b. Were au prior to death? 12 Ses	topsy findings available completion of cause of 2 No sify) ral Route Number,		
ctor. After this certificate has been signed by the attending ph / the funeral director, page 2 should be detached for use as the	To Be Completed by	Part II. Other significant conditions contributin 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Yatural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. 29a. Certifier (Check only 2 Medical Examiner: On	Inpatient 2 ★P/Out Date of Injury (Month, Day Year) Place of Injury - At home, far building, etc. (Specify) To the best of my knowledge the basis of examination and	tpatient 3 DOA Othining of 28c. Injury Work of 1 minury M 1 minury minury M 1 minus of the time of time of the tim	26. Place of Death er: 4 \(\triangle \) Nursing Hom y at x? Yes 2 \(\triangle \) No 2 ne, date and place, a pinion, death occurre a number	24a. Was an autopsy perform 1 2 2 2 (Check only one, the 5 Residen 8d. Describe how 8f. Location (Stree City or Town, and due to the caud at the time, dat	24b. Were au prior to death? 12 Ses	topsy findings available completion of cause of 2 No No No No Note of Cause of 2 No No Note of No No Note of No Note of No No Note of No No Note of No No Note of No No No No No No No No No No No No No		

		ŀ	1 - For State Registrar	State of Man	land / Depa/ <i>Cer</i>	artment of Heartificate of De	alth and Meath		enę () () g. No.	5 19694	
	Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Ye	3. Time of Death	
	/Medic		LILLIAN RAITEN					May	21 200		
,	Examin	er	4a. Facility Name (If not institution, give s Suburban Hospital	treet and number)		4b. City, Town, or Lo Bethesda	cation of Death		4c. County of E		
	Funeral Director		5. Social Security Number 6. Sex 1 092-01-6218	M aME	n yrs. last birthday) 35 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 21	Year) 9.	Birthplace (State or Foreign Country) New York	
	pur *		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits	
	Manyla 1 sho	JO.			Bethesda					1 ☐ Yes 2 X No	
	28a-	Director	Maryland Montgome: 10e. Street and Number	ГУ	bethesda	10f. Zip Code		10	g. Citizen of Wha	t Country?	
	h with		6111 Montrose Road	#723		20852		τ	J.S.A.		
õ	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or Items 23a or 28a-f show event. The Modical Examiner must be notified at	y Funeral	1 Never Married 2 Married	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2X No If Yes, Give		Was Decedent of Hispa f Yes, specify Cuban, M 1 ☐ Yes 2 No S	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc.	
3	hours	d by	3X Widowed 4 □ Divorced	Year or Dates:	160 Door	danta Haval Casunatia				Caucasian	
Maryland 21215-0036	e filed within 72 al Hygiene. I other than "nat vent, Inv wadie	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) -12-		life. I	dent's Usual Occupatio kind of work done duri DO NOT use retired) maker	n ng most of workir	lg 1	6b. Kind of Busine Own Home	·	
<u> </u>	filed Hygi other ent.	Be Co	17. Father's Name (First, Middle, Last)		Home		Mother's Name	(First, Middle, M		-	
	should be nd Mental marked o	To B	Benjamin Spector			1	Dora Fei	einstein			
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. of ca.	9 9	19a. Informant's Name/Relationship (Type, Print) Sharyn Tureck - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 8868 Applecross Lane Springfield, VA								
daitimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	1	-	natory or other place)	1		oc. Location · City	or Town, State	
	permit. Departm Importa any Inju		21. Signature of Funeral Service License	Erans	22	2. Name and Address o	of Facility J	effersor	n Funeral		
	Physician and Image as the burial-transit	al Examiner	23a. Part1. Enter the disease, or complic shock in heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	PSIS onsequence of): NIC Li onsequence of):	er the mode of dying, s				Approximate Interval Between Onset and Death	
P.O. Box 68760,	death e ette d for	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9						23d. Date of Month	delivery Day Year	
	Se 25 90	by	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause given i	n Part I.	23e. Did toba	1-6	te to the cause of death? Probably 4 Unknown	
VIIal Records,	0 - 0	Completed						24a. Was an autopsy perform	prior		
	yaician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?			26	6. Place of Death	(Check only one			
5	di S	ပ္	1 ☐ Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatien				nce 6 Other (S	Specify)	
DIVISION	Attending Proceeds. Sector: After by the funera	27. Manner of Death 10 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28a. Date of Injury - 28b. Time of Injury at Work? 1 Yes 2 No 28a. Date of Injury - At home, farm, street, factory, office						8d. Describe hov	w injury occurred		
5	ne Hospital or Attendi n 24 hours after ceath ne Funeral Director: A pletely filled in by the fi								eet and Number o State)	r Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after cleath. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examir one)	er: On the basis of ex and manner stated	amination and/or in 1.	vestigation, in my opini	on, death occurre	d at the time, da	te and place, and	due to the cause(s)	
	To the within 2 To the complet	Z	29b. Signature and title of certifier	nuanj	70.	Print) Print) Cullul (Le F	umber 7 666	29	d. Date signed (M	ionth, Day, Year)	
2	(6)		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type, 1/1/9 P	Print) OCUUICLE F	TICE, P	schi) (a	E, M9 2	0852	
	Sta Regista		31. Date filed (Month, Day, Year) MAY 3 1 2005	Registrar's	Signature	E.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 25, **Physician** Year 2005 Sandra L. Ray 1:20 P. M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1562 Crofton Parkway Crofton Anne Arundel 8. Date of Birth (Month, Day, Year) Apr. 5, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2∰F 260-66-1266 61 Yrs. Director Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or Itama 23a or 28a-f show traumatic event, the Medical Examin or most be notified at 1 X Yes 2 No Director Md. Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1562 Crofton Parkway 21114 USA Funeral ss 1 and 2 should be filed within 72 hours efter dea of Health and Mental Hygiene. Itsm 27 is marked other then "natural", or Itama other traumatic event. The Mudical Exercit 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Childrens Books 3 Writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret Brown James P. Lovett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1562 Crofton Parkway, Crofton, Maryland 21114 Richard D. Ray - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Its
any Injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 05-31-05 Alexandria, VA. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Fun al Service Licensee 6512 N.W. CRain Hwy., Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. blastonio Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 4□Pregnant at time of death been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes this certificate has autopsy 1□ Yes No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No neret Director: After this c filled in by the funeral dire 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Magner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Hospital or within 24 hours a To the Funeret D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check one) and manner stated. the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 31. Date filed (Month, Day, Year) State MAY 3 1 2005 Registrar

		•	1 - State of Maryland / Department State of Maryland / Certificate	t of Health and e of Death		giene () Reg. No.	05	19696	
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	Day	Year	3. Time of Death	
	/Medic		EMILY JUNE RUFFING		May 26			9:30 aM	
	Examin	er	5605 7 0	Town, or Location of Dea	ath		ty of Death		
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	verly 1 Year If Under 24 Hr		h		orge's place (State or Foreign	
	Funeral Director	1	256-24-2941 1 M 2 M F 82 Yrs. Months	Days Hours Mir	Jan. 1	y, Year) 3, 1923	Cou	ntry) nigan	
	ъ		Usual Residence of Decedent						
	irylan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit 1 X Yes 2 □ N			
	Be-f s	cto	Maryland Prince George's Cheverly						
	vith th	Director	10e. Street and Number 10f. Zip			10g. Citizen of	f What Cou	ntry?	
	s 238	- La		785	Caselle Van an Na	U.S.A.	ace - Ameri	een Indian	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examiner must be recitied at	Funeral		lent of Hispanic Origin? (ify Cuban, Mexican, Pue	erto Rican, etc.)		ack, White,		
21215-0036	urs af	þ	3 □ Widowed 4 □ Divorced Year or Dates: 1947	2⊠ No Specify:		Spec	ity: Wh	ite	
ğ	2 hou	Completed		Il Occupation	- 4-1	16b. Kind of	Business/In	dustry	
2	hin 7	ple	(Specify only highest grade completed) (Give kind of wor life. DO NOT us	e retired)	orking				
	od wit	Son	12 Administra					n Institute	
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle,	Maiden Suma	me)		
yla	ould Men arke	To	Unknown Bernardo	Adams					
Maryland	12 sh n and ram			(Street and Number or F				o Code)	
			Raymond L. Ruffing - Husband 5605 Jason 20a. Method of Disposition (Nan	n Street, Cl	heverly,	MD 207 20c. Location		own State	
Baltimore,	ages nt of l	٠.	1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or of	ther place)			•		
薑	it. Pa intme intant injury	. 3	'4 □Donation 5 □Other (Specify) MD Veterans C 21. Signature of Funeral Service Ucensee 22. Name an	emetery 5/	31/2005			Maryland	
Ba	permi Depa Impo any ir			Baltimore A			-		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	e of dying, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition Atherosclerotic Cardiov	vascular Hea	art Disea	ıse		Onset and Death	
Е	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
	LAGITITICI	L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	pe:	nlne	r any, leading to immediate bue to (or as a consequence or). Cause (Disease or injury						
	xecul and	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):						
58760,	icate be executed physician and s the buriat-transit								
687		edlcal	V						
Вох	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pr	ognanov.		23d. D	ate of deliv	ery	
Ω.	death	lcla	1 Yes 2 No 4 Pregnant at time of death 5 Other (sp.		N	fonth	Day Year		
P. 0.	res that the de signed by the a I be detached f	hys	9 ☐ Unknown		1100				
	es tha gned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributions.	ause given in Part I.				he cause of death?	
ord	w require been si should	ted			1 🗆 '	res 2∐No	3 ∐ Prot	bably 4 XUnknown	
Records,	e law r has be ge 2 sh	ple			24a. Was autop	sy	prior to co	opsy findings available impletion of cause of	
	The	Completed				rmed? 2 🖾 No	death?	2 No	
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?		eath (Check only o				
of	Physi this c	To	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO 27. Manner of Death 28a. Date of Injury 28b. Time of 12					fy)	
'n	ding F h. After funera	lon	1 XNatural 5 ☐ Pending (Month, Day Year) Injury	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	10w injury occi	irrea		
<u>s</u>	death death stor: / the	lcat	3 Suicide 6 Could not be		28f Location (Street and Num	her or Rur	al Route Number,	
Division	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director,	Certification:	4 Homicide determined building, etc. (Specify)	, 511100	City or Tox				
_	spita lours neral		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place	ce, and due to the	cause(s) and n	nanner as s	tated.	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one) 2 — Medical Examiner: On the basis of examination and/or investigation, and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c	: License number		29d. Date sign	ed (Month,	Day, Year)	
			Harada Blates	H005592	7	MAY	30	2005	
)	(10)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADON SV VSTON 3001 14050 THE	H005592	Chere	de,	her.	land	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 3 1 2005						
	negisti	ui .	MIMI O'I LOUS Plane A Grand						

			For State Registrar	State of M	faryland /		artmeni rtificate			ind Me	-	giene Reg. No.2	05	19597
	Physici	an	Decedent's Name (First, Middle,		D:#I						2. Date of De Jun 4,	ath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g	H.	Riffle	€	4h City	Town, or	Location o	f Death	Jun 4,		ty of Death	4:30pm ^м
	Examin	ier	Cumberland Villa					nberl				Alleg	•	
	Funeral Director		232-22-9118	Sex 7. A 1 ☑ M 2 ☐ F	Age (In yrs. last b 94	Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir Month, Da Feb 4,	th .1911	9. Birth Con	nplace (State or Foreign
	ith the Maryland or 28e-1 show	tor	Usual Residence of Decedent 10a. State 10b. County MD Alleg	any	10c. City, To		cation perlan	d						10d. Inside City Limits 1 1 Yes 2 □ No
	3e or 28e	i Director	10e. Street and Number 117 Somerville A	venue Apt.	8D		10f. Zip		21502	<u>)</u>		10g. Citizen of	What Co	untry?
036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show I.e Madical Examiter institucional	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Deceder Armed Force: 1	s? ₹No	1	Was Deced f Yes, spec 1 ☐ Yes 2	V	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No lican, etc.)		ace - Amer ack, White ify: Whi	
21215-0036	be filed stal Hygi of other event, L	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r.5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	uring most	of working	g	16b. Kind of I		,
and 2		To Be Co	17. Father's Name (First, Middle, La Lloyd Riffle	st)	16	iun					(First, Middle,	Maiden Suma		<u> </u>
Maryland	ges 1 and 2 should be it of Health and Mental if item 27 is marked or or other treumatic ev	Ī	19a. Informant's Name/Relationship Mary Riffle	(Турв, Print) dau	ghter 19	b. Mailir	Some	(Street a	nd Numbe Apt	r or Rural	Route Number	er, City or Town Derland	n, State, Z M	D 21502
Baltimore,	Pa ment ury		20a. Method of Disposition 1		20b. Place cemete Restlav	of Dispo ery, cren WN M	sition (Nam natory or or emoria	ne of ther place Il Gare	dens	Da 6	6/7/2005	20c. Location	•	own, State
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Lie	ensee AM	N	22					me, PA Cumbei	rland, MD	2150	2
	Physician		23a. Part. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	implications that caus ly one cause on each	ed the death. Do		er the mode	e of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>	resulting in death) Sequentially list conditions,	b. PN	as a consequence	NI	A							-
√ 00,	death certificate be executed to attending physician and ad for use as the burial-transit	i Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. C.	ARDIT	19(ILN	10N	ARY	A	RRE	57		
68760,	tificate be exig physician as the buria	ledicai		d										
P.O. Box	· 프로	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal deat at time of death		Ectopic pre Other (spe						ate of delig	very Day Year
	law requires that the sas been signed by 2 should be detact	by	Part II. Dther significant condition	s contributing to death	but not resulting	in the u	nderlying ca	ause give	n in Part I.			obacco use cor Yes 2 \(\square\) No		the cause of death?
Il Records,	The ate h page	Completed									24a. Was autor perfo 1 🗆 Yes			opsy findings available ompletion of cause of 2 \(\text{No} \)
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	/		(Check only o			
Division of	Jing After fune	H-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, L	iury 28b.	Time of Injury		8c. Injury Work		28		dence 6 🗆 Ot now injury occu		nty)
Divis	or Direction	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Flace of 1	Injury - At home, i etc. <i>(Specity)</i>	farm, str	eet, factory	, office		28	8f. Location (S City or Tov	Street and Num vn, State)	iber or Rui	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	icai	(Check only 2 Medical Ex	Physician: To the be- aminer: On the basis and manner	of examination a	ind/or inv	vestigation,	in my op	inion, deat	th occurred	d at the time,	date and place	, and due	stated. to the cause(s)
)	To the within To the comp	¥	29b. Signature and title of certifier	eu			29c	License	number 6 2 4	L20	7	29d. Date sign	ed (Month	Day, Year)
	4		29b. Signature and title of certifier 30. Name and address of person with the service of the se	o completed cause of	f death (Item 23a)) (Type,	Print)	ber	lan	d,	ND.	2150	2	
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) JUN 1 0	2005 32 egis	strar's Signature	Lo	and in	,		-				

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year :48 William John Selckmann 26 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. | 28, 1925 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1**⊠** M 2□ F Yrs. 80 219-16-6631 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County MD Anne Arundel 1 Yes 2 No Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 753 Whitneys Landing Road 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 No Specify: Specify. WWII 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lindley Packaging Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Selckmann Josephine Eick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Elizabeth Selckmann/Wife 753 Whitneys Landing Road, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 31, 2005 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD MD Veterans Cemetery 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of , neral Service Licenses 14 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo cardial Lour Due to (or as a consequence of): Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonseque) ce of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1☐ Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred

/Medical **Examiner** Examiner ed by the attending physician and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medical Completed or Attending Physicien: 2 hours after death. Inerel Director: After this y filled in by the funeral di Certification: To the Hospitel 24 hours a

Physician

/Medical

Examiner

Director

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Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Nedical Exercises must be notified at

2 should be fited within and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 Is n any injury or other traun

Pnysician

Baltimore, Maryland 21215-0036

28b. Time of **unk** 28c. Injury at Injury 1 Natural 2 Accident 5 Pending investigation М Maj 122005 1 Yes 2 No Fa 6 Could to be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 753 Whitneys 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home. Landing RD. Crownsville, MD 29a. Certifier

1 • Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number

74287

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burnia alen

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Red

within 2

		1	For State - State Registrer	te of Maryland /		artmen rtificate			and M		giene Reg. No.	2005	19699
	0.	- 15 m	1. Decedent's Name (First, Middle, Last)							2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Betty Lou Stotler							MAY	31	200	
7	Examin		4a. Facility Name (If not institution, give street as	nd number)		4b. City,	Town, or	Location o	of Death			ounty of Dea	
			Washington County H	ospital			На	gers	town.				on County
	Funeral	S	5. Social Security Number 6. Sex 1 ☐ M 20	7. Age (In yrs. last t	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da	y, Year)		rthplace (State or Foreign country)
	Director		217-32-6558 Usual Residence of Decedent	69	113.					March	9 193	6 Mai	ryland
	land ow		10a. State 10b. County	10c. City, To	wn or Lo	cation							10d. Inside City Limits
	Marylan f show lied at	ţ	Maryland Washington	На	gers	town							1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number		-	10f. Zip	Code				10g. Citize	en of What C	country?
	3a o	D	19704 Scott Hill Dr:	ive			2174	2			Un	ited S	States
	death ms 2	Jer	11. Marital Status 12. Was	s Decedent Ever in U.S. and Forces?	13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		. Race - Am	erican Indian,
9	or Ite	by Funeral	1 Never Married 2√2 Married 1 □	Yes 2X No es, Give	- 1	1 ☐ Yes		Specify:		tioan, etc.)		Black, Wh Specify: Wh	
5-0036	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show licel Estinities in ust be notified at	b b	3 ☐ Widowed 4 ☐ Divorced Yea	r or Dates:							تالما	pecny. 111	
5-	72 h	Completed	15. Decedent's Education (Specify only highest grade compl		a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa nk done c	ation Ju <i>ri</i> ng most	t of workit	ng	16b. Kind	d of Busines:	s/Industry
2121	within ene. than "	g E	Elementary/Secondary (0-12) Cott	ege (1-4or 5+)							Doo	r Com	
	filed v Hygie other t		17. Father's Name (First, Middle, Last)			Secre	tary		er's Name	(First, Middle,		r Comp	ally
ano	d be intal	Be c	Charles Ernest Reel										
2	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, Ite M.	2	19a. Informant's Name/Relationship (Type, Prin	nt) 15	9b. Mailir	na Address	(Street a			ussell I Route Numbe	er. City or	Town, State.	Zip Code)
Maryland	nd 2 salth an 27 is r trau												
	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28a-1 show other traumatic avent, Itle Mcdical Examinational be notified at		Roy G. Stotler (husba 20a. Method of Disposition	20b. Place	of Dispo	4 SCO sition (Nar	ne of	111,5	rive	Hager	Stown 20c. Loca	Maryı ation - City o	and 21742 r Town, State
2	permit. Pages 1 and Department of Healt Importent: If item 2's any injury or other 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Cedar		natory or o			Tune	6 05	Насол	retour	Maryland
Baltimore,		-	21. Signature of Funeral Service Licensee	1				1		~1~~ 7	Tage	LSCOWI	eral Home
Ba	Den Per Per Per Per Per Per Per Per Per Per		Il Jamiel O	Lan lour	ne 1	331 E	asto	rn Rl	vd.	gias A. N. Hage	reto	ry Fun	erai ноme yland 21742
			23a. Part 1. Enter the disease, or complications	that caused the death. Do								WII MAI	Approximate
	Obveision		shock, or heart failure. List only one caus Immediate Cause (Final		10	1							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	und CARC	NOV	7/1							6 MENTENS
	Examiner			20 (0 (0 20 2 00 100 00 00 00 00 00 00 00 00 00 00 00									
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oʻ	be execut ician and burial-tran	Ex	resulting in death) Last	ue to (or as a consequenc	e of):								
8760,	ate nys he	ical	d										
Ó	uffic 19 p	Physician/Med	IF FEMALE:										
Box	death cer e attendir ed for use	lan/	23b. Was decedent pregnant	es, outcome of pregnancy Live birth 2 Fetal dea		Ectopic pa					23	d. Date of de Month	elivery Day Year
	00	/sic	1 Vac 2 2 No 4	Pregnant al time of death Unknown	5	Other (sp	ecify)						,
P.0	res that the de signed by the a l be detached l		Part II. Other significant conditions contributing	g to death but not resulting	n in the u	nderlying c	ause dive	en in Part I		23e. Did t	obacco use	e contribute	to the cause of death?
Records,	requires that the een signed by th nould be detache	Completed by	RECURRENT MASSINE	()		noon, ang o	acco give		•	1.07	/		Probably 4 Unknown
Ö		etec	,			λ	07.00	~~		04- 146-		Odb Ware 6	outenay findings available
3ec	e lav has je 2	ldm		E PULMON,		131	104	6		24a. Was autor	an osy ormed?	prior to death?	tutopsy findings available completion of cause of
E	i cian: The l certificate ha rector. page			ARDIOVASCI	ULA	RD	150		,	1 ☐ Yes	2/2/No	1 □ Ye	s 2 No
Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?				Othe	200		(Check only o			
ō	Phys this ral di	. To	1 res 4 No	1 Inpatient 22 ER/	Outpatier Time o)A	4 190	-	ne 5 🗆 Resi			ecify)
LO O	Attending F r death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	28c. Injury Work	<br Yes 2 □ I					
Signature Sign							Number or f	Rural Route Number,					
2	after after Dire			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, State)					
27. Manner of Death 1									cause(s) a	nd manner a	as stated.		
	the Ho the Fu npletely	edical	(Check only 2 Medical Examiner: Or one)	and/or in	vestigation	, in my o _l	pinion, dea	ith occurre	ed at the time.	date and p	lace, and du	ie to the cause(s)	
	To the To the Comp	29b. Signature and title of certifier	29c. License number 29d. Date signed (M						signed (Mor	nth. Day, Year)			
			Parel Val A	redfort			23	3889.	2		(6/2/0	5
1 1 .			30. Name and address of person who complete	d cause of death (Item 23a	а) (Туре,	Print) 5	VITE	5 /3	30		14	AG BRI	MUOTI
SH-	6		PAMELA FOX BRADA	ORD, MD	11110	MED	ICA	CA	MAU.	r R8	M	8	21742
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	,	har the	,						
	Regist	ar	JUN 0 3 2005	Mileen D.	· P	The same	-						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Пач Year **Physician** Sarah Louise STARKEY 07:40M 3 2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours | Min. 8. Date of Birth (Month, Day, Year) April 15, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Alabama 84 Director 418-26-8627 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28e-f show 1 XYes 2 ☐ No Directo Maryland Washington Hagerstown 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number with 1210 Rabbit Court 21740 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status rthan "neturel", or Item The Medical Examiner filed within 72 hours after 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 [X] No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene homemaker her own home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Pages 1 and 2 should be Oscar Taylor Arlevia Cannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ourtment of Health a cortant: If item 27 is injury or other tra Harry C. Starkey, Jr. - son 1210 Rabbit Court, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Department of Important: If any injury or once. Louisville Cemetery 6 - 3 - 05Louisville, Alabama 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IDIOPATHIC PULMOHAFY FIBROSIS Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, by Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MABETES MELLITUS, PULMONARY MYPERTE-1 Yes 2 No 3 Probably 4 Unknown Completed MY PERTENSION, CORONARY 24b. Were autopsy findings available prior to completion of cause of death? MSIDM. 24a. Was an ate has bage 2 s autopsy performed ARTERY DISCIPLE 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 To the recommend of the deam.

Within 24 hours after deam.

To the Funerel Director: After the funeral director. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD 0 62327 5/31/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hog. Md 21740 mill 68 Jansa 31. Date filed (Month. 32. Registrar's Signature Year, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 22:48PM SALI 25 -AELDIN 2005 mai /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner OhMS Age (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Hours 1**☑**M 2□F 229-23-1359 79 Sudan Director Mar.1,1926 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State worls "natural", or items 23a or 28a-f shov edical Examiner must be positive at 1 Yes 2 No Montgomery Burtonsville Maryland by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20866 USA 15123 Red Cedar Dr. Pages 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene. ant: If item 271s marked other than "natural", or items 23i Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☑ Married ∐Yes 2 **X**No Yes Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyBlack 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Constrution Carpenter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fathia S. Omer Badawi Salih 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15123 Red Cedar Dr, Burtonsville, Md. 20866 Sharaf Saleh-Son-in-Law Department of Health Important: If item 27 y or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Family Cemetery 5-31-05 Khartoum, Sudan 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Universal II Mortuary Inc. 21. Signature of Funeral Service Licensee any ir 411 Kennedy St, N.W., Wash, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause operator line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hypotension 30 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 weeks failure heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician pe (Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. the a 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Certification: After Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number KASSAHUN, MID 29b. Signature and title of certifier HELIWA 2 RES - 00 0 25, May 2005 inclumel. MD 2 HUPICINS MOSPITAL: HELTWA KASSAHUW, MIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) フいたいム NORTH WOLFE BACTIMORE STREET MARYLAND 21287 600 31. Date filed (Month, Day, Year) 326Registrar's Signature State 27 MAY 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 11:05 P M May 24, 2005 Edna Suitt W. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Y) 6-2-1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** 1 ☐ M 2 🙀 F 86 North Carolina 244-18-9545 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County na 23a or 28a-f show 1 ☐ Yes 2 X No Directo Davidsonville Maryland Anne Arundel 10g, Citizen of What Country? 10f. Zin Code 10e. Street and Number 21035 IISA 846 W. Central Avenue Completed by Funerai Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍎 No If Yes, Give Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than "nature traumatic event, II we Madical Elementary/Secondary (0-12) 12th College (1-4or 5+) Telephone Operator Telephone Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental and Mental Lola Duke Robert R. Radford ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) thealth Item 27 I Raye S. Long/ Daughter 633 Hillmeade Rd., Edgewater, MD 21037 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If Ite any injury or of once. XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5-27-05 Davidsonville, MD Lakemont Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Puneral Service Censes 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Stroke (CVA) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Atrial Fibrillation Due to (or as a consequence of) Box 68760, nding physician Hypertension Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 9 Dunknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Coronary artery disease director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Peripheral vascular disease 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 💢 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Manner of Death After Injury 1XXVIatural 5 Pending investigation 1 🗀 Yes 2 🗆 No after death. 2 Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide determined filled in by 4 Homicide within 24 hours a To the Funeral C (XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 who completed cause of death (Item 23a) (Type, Print) ·UNIB. BLUD 54176326 Mame and address of person 34 14 W CHARD 32. Resistrar's Signature 31. Date filed (Month. Day State Registrar

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32	Funeral Director		5. Social Security Number 6. 5 5 7 9 - 1 5 - 0 3 2 2	Sex 7. Ag 1XIM 2□F	e (In yrs. Ia 33	st birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 09 1	Υθα <i>r)</i> 4 71		place (State or Foreign intry) nsylvania
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936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be rutilled and once.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:		i	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2X No	panic Origin? (Sp. Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Amer Black, White Specify: Bla	, etc.
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	an A		30. Name and address of person who	Mull, mD o completed cause of	death (Item	23a) /Type	OCI	ME ————————————————————————————————————		May	21 20	005
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2005 1.15 William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number ta If Under 24 Hrs. TIMOR 8. Date of Birth (Month, Day, Year) NOV 2, 192 Birthplace (State or Foreign Country) 6 SAX 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 1 2 F Yrs. 219 01 2645 84 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 28a-f show treumatic event, the Medical Exer-treer must be notified at 1 □Yes 2X No Directo MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21208 202 McHenry Avenue United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 232 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2€ No Specify: Completed by 3 - Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Electronics Engineer Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary E. Kester Anton Stitz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pat Kuchta/Daughter 310 Pepperwood Street Coppell TX 75019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6-1-2005 Baltimore, MD `4 □ Donation 5 NOther (Specify)entombment Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. Coll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Infarction mencerdish disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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		For State	State of M	•	partment of H		ental Hygi	ene	
		Registrar		<u> </u>	ertificate of	Death		g. No.	
Physici /Medi		Decedent's Name (First, Middle Harvey	Emerson	Sweitze	er		2. Date of Death Month June	3, 200 £	3. Time of Death
Examir	ner	4a. Facility Name (If not institution, Lions Manor Nul			4b. City, Town, o	r Location of Death		4c. County of Dea	ith
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Mith the	I Director	10e. Street and Number 12822 McKay Av	venue		10f. Zip Code	21502	10	g. Citizen of What C	ountry?
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ould be til Mental H brked oth atic even	To Be	17. Father's Name (First, Middle, I John C. Sweit				18. Mother's Name Homa A	. Sweitze		
and 2 sho saith and n 27 is m		19a. Informant's Name/Relationsh Alberta Sweitzer	1 1 21 1		ailing Address <i>(Street</i> 822 McKay		Cresap		Zip Code) D 21502
Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation '4 □ Donation 5 □ Other (Sp.		compton c	sposition (Name of crematory or other pla emetery	ce)		Oc. Location - City or Swanton	Town, State
permit. Departr Importa any inje		21. Signature of Funeral Service I	Licensee	11/1		ess of Facility I Funeral Ho		ind, MD 2150	12
nysician /Medical		23a. Part 1. Enfor the disease, or shock, of heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each li	ine.	enter the mode of dyin	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death 2 Years
Examiner	ner	Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying	b. ———	a cur sequence of).					
s be executed sician and burial-transit	cal Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of);					
= > <u>*</u>	P								
e death certificate be the attending physicia hed for use as the bur	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
ures that the death certificate signed by the attending phy Id be detached for use as the	d by Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death It time of death	5 Other (specify)			Month	Day Year o the cause of death?
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State Registrar

31. Date filed (Month, Day, Year)

JUN 1 0 2005

Registrar's Signature

		For State Registrar	State	of Marylan		rtment of H		and M		giene	105	197	0.7
		Decedent's Name (First, Middle	e, Last)						2. Date of Dea		Voce	3. Time of D	Death
Physici /Medi		Shirley	Jane	S	ummer	S			JUNE	7	2005	1345	М
Examir		4a. Facility Name (If not institution		number)		4b. City, Town, or		of Death			ounty of Deatl	h	
		MEMORIAL HOSPI' 5. Social Security Number	TAL 6. Sex	7. Age (In yrs.	last hidhday)	CUMBERLA If Under 1 Year	AND If Under	24 Hrs.	8. Date of Birt		EGANY	nolono (Ctoto or	Familia
Funeral Director		216-34-7079	1 M 2 XF		Yrs.	Months Days	Hours	Min.	Aug 2	3, 193	7	nplace (State or untry)	roreign
pun *	1	Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or Lo	cation						10d. Inside City	v Limits
iled within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or items 23a or 28e-f show ent, the Medical Evander most be notified at	ō		gany			perland						1 Ves	•
r 28e	rec	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Co	untry?	
th with	Funeral Director	1616 Frederick	Street				21502	2			USA		
r deal	ner	11. Marital Status	Armod	ecedent Ever in U Forces?	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	- 14.	Race - Amer		
s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes,	s 2 No Give r Dates:	1	□Yes 2No	Specify:			Sį	pecify: wh	ite	
tural		15. Deceden	it's Education		t6a. Deced	lent's Usual Occupa	ation			16b. Kind	of Business/l		
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ed wit ygiene ygiene t.	Completed	12			teache	r				pre-s			
al yidling 2.12 should be filed with nd Mental Hygiene. s marked other the umatic event, I.c.	To Be	17. Father's Name (First, Middle, Albert Charle		ich					(First, Middle. ertrude		,	ee	
National Shringh and 2 Shringh and 27 is m		19a. Informant's Name/Relations James Summe	ship (Type, Print)	nusband	19b. Mailin 1616	g Address (Street a 5 Frederic	k Stre	er or Rura eet	Cumb	or, City or T Derlan	own, State, Z d M	D 21502	2
of Health of Health of ritem 27 is		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Romaval fra	0	emetery, cren	sition (Name of natory or other place	θ).		ate		tion - City or		
Pages ment of the out		'4 □ Donation 5 □ Other (5		Re	stlawn M	emorial Gar	dens		6/10/2005	LaV	ale	M	D
partillore, permit. Pages 1 a Department of Her Importent: If item eny injury or othe aggree.		21. Signature of Funeral Service	Licensee	MM.	22	Nam Sæd Adden 108 Viro			ome, PA : Cumber	land N	/ID 2150	2	-
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Physician		Immediate Cause (Final disease or condition	61	_)hsta	uctive	1110	0 1	Disen	SP		Onset and De	eath
/Medical Examiner		resulting in death)	W. 3	to (or as a conseq	juence of):	CIIIC		9 .				1,400	
LAGITATION	e.	Sequentially list conditions, if any, leading to immediate	b	to (or as a conseq	uence of):								
uted I Insit	mine	Cause (Disease or injury	< □		331.00 317.								
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The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		L d										
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the d	nyslo	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	9 Un		Jean 3	Ottier (specify)							
ies that the signed by the detach	by PI	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of de	ath?
w requires been signed should be									1 🗆 Y	′es 2□N	No 3□Pro	bably 4 🗹 Ur	nknown
law reas be	ompleted								24a. Was		24b. Were aut	topsy findings as	vailable use of
	Con								perfo	2 No	death?	2□ No	
VII.c	Be	25. Was case referred to medica examiner?	Hespital			Othe			(Check only o				
this aldi	5 1	1 ☐ Yes 2 ☑ No 27. Manner of Death	11		ER/Outpatien 28b. Time of				me 5 Resid			eify)	
VISION OF VICE Attending Physicien: or death. ector: After this certific by the funeral director,	atlon	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (M igation	te of Injury onth, Day Year)	Injury	28c. Injury Work	k? Yes 2 □ i						
Atter ar dea ector by the	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined 288. Pla	ace of Injury - At h	ome, farm, stre	eet, factory, office		2	28f. Location (S	Street and N	lumber or Ru	ral Route Numb	er,
itel or rs after el Dir	Cert												
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	the best of my know basis of examina anner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	ne, date an pinion, dea	d place, a th occurre	and due to the o	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
To the vithing To the comp	ž	29b. Signature and title of certifie	17/2	//		29c. License					igned (Month		Ŀ
		• (// m/ Z			D367	66			some	8,20		
9		30. Name and address of person VIK POONAI, M.D.		ause of death (Iter ETON DRI		Print) IBERLAND,	MD 2	1502					
St		31. Date filed (Month, Day, Year,) 32	. Pogistrar's Signa	ature								

			1- State Registraramend item	State of Ma #5 per inf	aryland / De g844 6	epartment of F	lealth and N Death	Mental Hygie	6005	19708
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	Hazel	Schatz			2. Date of Death Month	Day Year	3. Time of Death 9:65 AM
	Examin		4a. Facility Name (If not institution, give	rt Hes	1	Ciem	r Location of Death Crlav If Under 24 Hrs.	d	Allega	ny
	Funeral Director		5. Social Security Number 478-05-3415 570 Usual Residence of Decedent	M 20 (F / Age	92 Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day, You November 11		hplace (State or Foreign untry) Maryland
	Maryland e-f ahow illisatat	ctor	10a. State 10b. County Alle	gany	10c. City, Town		Lonaconing			10d. Inside City Limits 1 Yes 2 No
	th with the 23e or 28 ist be no	al Director	10e. Street and Number 2 Beech	wood Street		10f. Zip Code	21539	10g	. Citizen of What Co US	
036	be filed within 72 hours after death with the Maryland hat Hygiene. do other than "natural", or items 23e or 28e-f ahow avent, the Musical Ere ill af mint be rediffed at	l by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3. ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces 1 Yes 2 X I I Yes, Give Year or Dates:		13. Was Decedent of Hif Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
215-0	within 72 ho lene. than "natur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of world)	king 16	b. Kind of Business/I	
Maryland 21215-0036	be filed wil tal Hygien d othar th	Be Con	12 17. Father's Name (First, Middle, Last)	0		3	upervisor 18. Mother's Nam	ne (First, Middle, Ma.	Governme iden Sumame) e Trezise	ent worker
arylar	2 should be and Mental la marked o aumatic ave	To	19a. Informant's Name/Relationship (7			failing Address (Street	and Number or Ru			lip Code) ,
re, Ma	1 and Health am 27 ther tr		Hazel Burdock	c - Niece	20b. Place of D	isposition (Name of		t, Lonaconing, I	Maryland, 2153	
Baltimore,	Page:		1 🕱 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify)		urel Hill Cemete	ry	June 09, 2005	Moscow Mil	ls, Maryland
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service Licent				enzie Funeral			ning, Md. 21539
	Physician /Medical Examiner		23a. Fault. Enter the disease of compensations, or heart failure. List only disease or condition resulting in death)	a Se	a consequence of	Syn d		or respiratory arrest		Approximate Interval Batween Onset and Death // Lary S
■ √		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease of highly that initiated events resulting in death) Last	c	a consequence of					
8760,	cate be executed physician and the buriat-transit	dicai		d						
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and to has been signed by the attending physician ransit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	1		23d. Date of deli Month	very Day Year
۵	n requires that the de been signed by the s should be detached to	by	Part II. Other significant conditions co	entributing to death b	ut not resulting in t	he underlying cause given to pres	en in Part I.		cco use contribute to	
Vital Records,	The law recate has bee page 2 sho	ompleted	typi thy ro	idism	Den	bentia be	arenia	24a. Was an autopsy performed	d2 prior to death?	topsy findings available completion of cause of
	sician: certifica rector, p	o Be C	25. Was case referred to medical examiner?	Hospital: 1 Hopatie	ent 2 ER/Outp	cart. atient 3 DOA Oth	0.0	th (Check only one)		
ion of	ding h. After fune	\vdash	27. Manner of Death De	28a. Date of Inju (Month, Da)	ry 28b. Tir	ne of 28c. Injury	y at	28d. Describe how		ary)
Division	i Zir e	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farn c. (Specify)	n, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	Fur 4 9	edical C	(Check only 2 Medical Exam	iner: On the basis of	f examination and/	death occurred at the ti or investigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	~~		29c. Licens	e number	29d.	Date signed (Month	n, Day, Year)
	1	1	30. Name and address of person who of	completed cause of d	eath (Item 23a) (T	ype, Print)	Fros Hu	rs Mar.	Innd 7	1(3)
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 0 20	05 32 Registra	ar's Signature	29c. Licens ype, Print) S Creek	L	<i>J1</i>	,	

State of Maryland / Department of Health and Mental Hygiene 1- State Registra AMEND#4as 26perMD5/27/05, BMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** РМ 5:00 May 19, 2005 Joan Marie Templeton /Medical 4a. Facility Name (If not institution give street and number)
600 block Deerfield Drive 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. May 30, 19 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 21 F Yrs. 75 Director 579.42.0401 1929 St. Louis, MO Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r then "neturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Montgomery Aspen Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 3903 Wendy Lane 20906 death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. In Importent: If item 27 is marked other then "neturel", or Ite may injury or other treumetic event, the Medical Examina once. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12th Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Victor Gauger Evelyn Wilhelmina Wissmath ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Potomac Drive, Iowa City, Iowa 52245 William L. Gauger/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Fort Lincoln Crematory 5/24/2005 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. Na 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pulmonary Embolism Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Metastatic Uterine Cancer 4 Years Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed peeu Diabetes Mellitus, Non Insulin Dependent 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 21🛣 No 1 ☐ Yes 2 ☐ No Hypertension Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) In car in residential
Other:
4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient ပ 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death of or Attending Parter death. Certification: 1 ANatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗌 Suicide 6 Could not be determined 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours af To the Funerel D 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 23, 2005 D-25344 012 \mathcal{V}^0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p Ginsberg, M.D., 2415 Musgrove Road, Suite #209, Silver Spring, MD 20904 Robert J. 31. Date filed (Month, . Registrar's Signature State Registrar

		-	Piea For State Registrar			yland / Dep	artment of F	lealth and N	Mental Hyg	_	05	19710
	Physicia		Decedent's Name (First, Middle	_	urno				June 5,		Year	3. Time of Death 1615 M
	/Medic	al	4e. Fecility Name (If not institution	argaret T			4b. City. Town, o	r Location of Death		4c. County	of Death	1013
	Examin	er	Homewood at C					lerick			deri	k
-	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday,	1	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 2	OY ear) 4 O O C	9. Birthp	lace (State or Foreign try) 1 and
	Director		216-22-8928 Usual Residence of Decedent	1□M % XXF		76 Yrs.	Months Days		April 2	9, 1929	Mai	rý Land
	yland Jow		10a. State 10b. County		1	IOc. City, Town or L					1	Od. Inside City Limits
	a-f sh	ctor	Maryland Fred	erick		Frederi	ck					1 ☐ Yes 2Ã No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be invitted at	Funeral Director	10e. Street and Number 7407 Willow	Road			10f. Zip Code 21702		1	U.S.A		itry?
	death	ner	11. Marital Status	12. Was De	cedent Ev	er in U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White,	
21215-0036	72 hours after death w *natural, or Items 23a dical Examiner must t	by Fu	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Vac (Forces? 2 (X)No Sive Dates:		1☐Yes 2XNo	Specify:		Specif	y: Whi	te
2-0	72 ho	eted	15. Deceder (Specify only highe	nt's Education	d)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	nation during most of wor	king	16b. Kind of B	usiness/In	dustry
21	within ene. then	Be Completed by	Elementary/Secondary (0-12)		(1-4or 5+	1	s/Cashier			Retail	Sa1	es.
2	e filed within at Hygiene. I other than vent, the Me	ပ္	17. Father's Name (First, Middle,	Last)		Jare	37 Gastifet		ne (First, Middle,			
and	Mental Merked o	To Be	George	Lester I	ry			Mary	Catheri	ne Cast	:le	
Maryland	d 2 should be th and Menta th and Menta tis marked traumatic ev	_	19a. Informant's Name/Relations Mrs. Anna Mari	ship (Type, Print)		T.	ing Address <i>(Street</i> 94 Hawkir			-		Code) 21701
	f Heal item 2 other		20a. Method of Disposition			20b. Place of Disp		ce)	Date	20c. Location		wn, State
Baltimore,	Page ment o ant: If ury or		1	Specify)	m State	Mount Oliv	et Cemetery	June 8,	-			Maryland
Ball	permit. Deportr Imports any nji		21. Signature of Funeral Service	Licensee	/	M00255	²Keeneyor 106 East	ind Basfo Church S	rd PA Fu t., Fred	neral H erick,	Nome	21701
	Physician /Medical		23a. Part 1. Enter the disease, o shock, or hear failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complications that tonly one cause r	m lo	homa	iter the mode of dyli	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner			b. Re	nul	consequence of):	e					1 year
J	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events	d Due t	to (or as a	consequence of):						>14-
o f	be executed ician and burial-transil		resulting in death) Last		•	consequence of):	0					
68760		dicai		L _{d.} Co	one	ary Arete	ng Wise	176				150
P.O. Box (The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 m https? 1 □ Yes 2 ☑ No 9 □ Unknown		e birth 2 egnant at t	Fetal death 3	□Ectopic pregnand □ Other (specify) _	у			ate of deliver	ery Day Year
	ires that signed k		Part II. Other significant condit	ions contributing to	death but	not resulting in the	underlying cause gr	ven in Part I.		bacco use cor 'es 2□No	itribute to t 3 □ Prot	he cause of death?
Sor	w require been sig should t	ietec		Sleep	An	100			24a. Was	an 24b.	Were auto	opsy findings available
of Vital Records,	ysician: The lav is certificate has director, page 2	Completed by	OBINATIA	م های د	()()	- CCC				rmed? 2 No	prior to co death? 1 \(\text{Yes}	mpletion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Hogoital:			- Ot	har	ath (Check only o			
ot		-T	1 Yes 2 No	28a Da	te of Injury	t 2 ER/Outpati	of 28c. Iniu	irv at	dome 5 Resid			(y)
	Attending Physician: r death. ector: After this certifics by the funeral director. p	tion	1 Natural 5 ☐ Pend	/4.4	lonth, Day	Year) Injury	Wo	ork?]Yes 2 □No				
Division	or Attendiater death Director: A	Certification:	3 Suicide 6 ☐ Could	minor 208. Fle	ace of Injurial	ry - At home, farm, s (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rur	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier 1 Certify (Check only 2 Medical	I Exeminer: On the	the best o e basis of anner stat	f my knowledge, de examination and/or ed.	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and n date and place	nanner as s , and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certif	11 /	he	1100		se number 4 8		29d. Date sign		Day, Year)
	0		30. Name and address of perso	n who completed c	ause of de							
	8		Martha J.				Ninth St	treet, Fr	ederick,	Maryla	and 2	1701
	St	ate	31. Date filed (Month, Day, Yea	1 n 2005 32	2. Redistra	r's Signature	South D					

DHMH 17 Rev 1/2001

0.0.0 6/5/05

Anna Margaret lurner

ORIGINAL

BENNETT

4a. Facility Name (If not institution, give street and number)

MANOR CARE NURSING HOME

1 □ M 2 😿 F

1. Decedent's Name (First, Middle, Lest)

5. Social Security Number

Physician

/Medical

Examiner

Funeral

If Under 1 Year

Days

VEGIARD

Yrs.

7. Age (In yrs. last birthday)

3. Time of Death

5:00 AM

2. Date of Death Month

26, MAY 2005 4b. City. Town, or Location of Death 4c. County of Death

MONTGOMERY

CHEVY CHASE If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

 Birthplace (State or Foreign Country) **ENGLAND**

SEPT. 6, 1915

10d. Inside City Limits 1 Yes 2 □ No

10g. Citizen of What Country?

U.S.A. 14. Race - American Indian, Black, White, etc.

Specify WHITE

16b. Kind of Business/Industry

NONE

18. Mother's Name (First, Middle, Maiden Surname)

AUSTIN

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)

MD. 20854 20c. Location - City or Town, State

RIVERDALE, MD.

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.

5801 CLEVELAND AVE., RIVERDALE, MD.

Approximate Interval Between Onset and Death

23b. Did tobecco use contribute to the ceuse of deeth?

			0000 01 0001.
1 ☐ Yes	2□ No	3 🗌 Probably	4X Unknow

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 ☐ Yes 1 □ Yes 2 □ No.

2 X No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

D20274 MAY 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOHRA, M.D. 7710 BRADLEY BLVD., BETHESDA, MD. 20817

31. Date filed (Month, Day, Year) MAY 2 7 State

29a, Certifier

29b. Signature and title of certifier

Medical

Registrar's Signature

Registrar

To the

		1 - For Stete Registrar	State of Maryland		rtificate c		i wentai ny	Reg. No	.UUJ	19712
Dhysisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of De	eath Da	y Year	3. Time of Death
Physici /Medic		Rachel Louis	e Watson				May 2		2005	0250 M
Examin		4a. Facility Name (If not institution, g			4b. City, Town	n, or Location of De	ath	4c.	. County of Death	1
		Dorchester Gene			Cambri				Dorches	
Funeral		1	Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Da		n. (Month, Da	ay, Year)	9. Birth	place (State or Foreign intry)
Director		217-40-9864 Usuel Residence of Decedent	61				Nov. 2	20, 1	1943 Nor	th Carolin
Maryland f show		10a. State 10b. County	10c. City, T	own or Lo	cation				1	10d. Inside City Limits
Man Man	to	Maryland Dorche	ster	Hurlo	ock.					1 1 Yos 2 No
r 28a	irec	10e. Street and Number		I ICI L	10f. Zip Cod	e		10g. Cit	izen of What Cou	ıntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Informatic thems 23a or 28a-f show any injury or other traumatic event, the Medical Eranical must be notified at once.	Completed by Funeral Director	106 Andrews Stre	et		21	L643			USA	
deal	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent	of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No)-	14. Race - Amer	
or Ite	F	1 Never Married 2 Married	1 Yes 2 100	[1 Tes, specily C	- Andrews	eno Hican, etc.)		Black, White	, etc.
nd within 72 hours after giene. er than "natural", or Ite the Medical Examina	db	3 Widowed 4 Divorced	Year or Dates:		10165 2097	No <i>Зреспу:</i>			Specify: Wh:	ite
72 h 'natu	ete	15. Decedent's I (Specify only highest g	Education 1 rade completed)	6a. Deced	ient's Usual Oc	cupation ne during most of w tired)	orkina	16b. K	ind of Business/Ir	
vithin ne. han	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)							
filed v Hygie ther t		17. Father's Name (First, Middle, Las	41	h	lomemake				<u>Nyn Home</u>	
ould be fi Mental I- arked ot atic ever	Be	Garnie Brown	i)				ame (First, Middle,	, Maiden	Sumame)	
d Me nark natic	ပို	·	(T 0)			- !	Brown			
nd 2 should be file th and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relationship				eet and Number or F				p Code)
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Paul B. Watson,			Andrews sition (Name of	Street,	Hurlock,		21643	- Chan
Pages nent of I		1 Burial 2 ☐ Cremation 3	☐Removal from State ceme	etery, cren	natory or other p	olace)			ocation - City or T	own, State
bermit. Pages 1 a Department of Hes mportant: If item any injury or othe		'4 □Donation 5 □ Other (Spec	ify) Sprir			Gardens 5	5/31/2005	Не	bron, Ma	aryland
permi Depa Impo any ir		21. Signature of Funeral Service Lice	onsee .	. a C	. Name and Ad	dress of Facility romwell F	umeral H	ione.	PΔ	
		230 Bar Farra	Koncur	3	08 High	romwell F St., Can	bridge,	MD,	21673	
FIRE		23a. P rt1. F ter the disease, or conshool, or heart failure. List only	one cause on each line.	o not ente	er the mode of o	rying, such as cardi	ac or respiratory ai	rrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. NOW-Small	cell	Lung	CONCLE				Ondot and Dodin
/Medical Examiner		1	Own Mix Obs	ce of):	nu mul	m DATATE	diseasa			
(重要) 省	-	Sequentially list conditions,	b. Due to (or as a consequent		100	9	411 Case			
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	= = = = (== == = = = = = = = = = = = =	0.,.						
al-tra	Exal	resulting in death) Last	c. Due to (or as a consequence	ce of):						
cate be executed physician and the burial-transit	icai		o d							
ificate g phy as the			u							
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					3	23d. Date of delive	an/
death s atte	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnal Other (specify)			"	Month	Day Year
that the de ed by the detached	ysi	9 Unknown	9□ Unknown		(-,,					
res that igned b	by Pi	Part II. Other significant conditions	contributing to death but not resulting	g in the un	derlying cause	given in Part I.	23e. Did to	obacco u	se contribute to t	he cause of death?
quire n sìg uld be		congestive He	art failure				15	es 2[□No 3 □ Prot	oably 4 Unknown
The law requires the has been signed age 2 should be considered.	Completed	diabetes me	llitur		-		24a. Was	20	24h Wara auto	psy findings available
he la e has ige 2	щ						autop		prior to co death?	mpletion of cause of
in: T ificat or, pe	č.	25. Was case referred to medical				00.51	1 ☐ Yes	2 No	1 🗆 Yes	2 □ No
ysician: The law is certificate has t director, page 2 s	m	examiner?	Hospital:	Outpatient	3□ DOA	N	eath (Check only o	1		
Phys ar this aral di	: To	27. Manner of Death	The same of the sa	o. Time of	28c. In	iurv at	Home 5 Resid			у)
ding P th. : After s funera	를	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	W	Vork? □Yes 2□No				
- 4 - 4	2	3 Suicide 6 Could not	28e. Place of Injury - At home.	farm, stre	et, factory, offic	æ	28f. Location (S	Street and	d Number or Rura	al Route Number.
Attendir r death. sctor: Af by the fu	10-0	4 Homicide determined	building, etc. (Specify)				City or Tow	vn, State))	
al or Attending Physician; after death, I Director: After this certifica d in by the funeral director, I	ertif	_					1	201122/21		
spital or Atte	al Certification:	29a. Certifier 1 Certifying P	hysicien: To the best of my knowled	ige, death	occurred at the	time, date and place	e, and due to the o	causeisi	and manner as s	tated.
Hospital 4 hours a Funeral I ely filled		29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	hysicien: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the estigation, in my	time, date and plac y opinion, death occ	e, and due to the curred at the time, o	date and	and manner as s place, and due to	tated. the cause(s)
Hospital 4 hours a Funeral I ely filled	Medical Certifi	Check only Z Medicel Exe	miner: On the basis of examination	dge, death and/or inv	estigation, in my	y opinion, death occ	curred at the time, o	date and	place, and due to	Day, Year)
_ 0		one) 2 medicel Exe	miner: On the basis of examination	dge, death and/or inv	estigation, in my	y opinion, death occ	curred at the time, o	date and	place, and due to	the cause(s)
Hospital 4 hours a Funeral I ely filled		29b. Signature and title of certifier	and manner stated.	and/or inv	29c. Lice	onse number	surred at the time, o	29d. Date	e signed (Month,	Day, Year) ZOUS
Hospital 4 hours a Funeral I ely filled		29b. Signature and title of certifier 30. Name and address of person who	and manner stated.	and/or inv	29c. Lice	y opinion, death occ	surred at the time, o	29d. Date	e signed (Month,	Day, Year)

DHMH 17 Rev 1/2001

				1 - For State Registrar	State of	Maryland / D		nt of H		lental Hy	giene () ()	5	19713
		Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	.Day	Year	3. Time of Death
		Physici /Medio		Louise Whitfi						May a	24 20	05	11 35am
		Examir	ner	4a. Facility Name (If not institution, giv		ber)			r Location of Death	,	4c. County Princ		rans
				Doctors Hospita 5. Social Security Number 6. S		. Age (In yrs. last birt		nhan or 1 Year	I If Under 24 Hrs.	8 Date of Birt			-
		Funeral Director		252-38-9190	1 M 2		Yrs. Months		Hours Min.	8. Date of Birt (Month, Da 03 06	1938	Unkno	ace (State or Foreign ry) WN
		and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10	d. Inside City Limits
		Maryla	tor	MD Prince	Georges		ol Heig	ghts					Y Yes 2 No
		ith the	Direc	10e. Street and Number				p Code			10g. Citizen of W	/hat Countr	ry?
		s 23s	ra	5607 Jefferson H				0743	lianania Orinia? /Ca	a a if a Van au Na	USA	- America	a ladios
7	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "naturel', or items 23a or 28e-f show any Injury or other treumatic event, it a Nedical Examinational by Indified at Once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☼ Widowed 4 □ Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	2 ⊠ No	If Yes, sp		dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes of No Rican, etc.)		k, White, et	tc.
Whitfield	21215-0036	72 hour	eted t	15. Decedent's E (Specify only highest gra	ducation	16a.	Decedent's Usi	al Occup	pation during most of work	ina	16b. Kind of Bu	siness/Indu	ustry
#	121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-	40r 5+)	NUrs		during most of work d)		Whitfie	1d Nu	ırsing
~	d 2	filed Hygi other	e C	17. Father's Name (First, Middle, Last		rs.	NULS	E	18. Mother's Nam	e (First, Middle,			1101118
2	an	lid be lental rked rked	To Be	Unknown					Unknow	n			
	Maryland	2 shou and N Is mai	[19a. Informant's Name/Relationship (Турө, Print)				and Number or Run				
3	≥	l and leelth im 27 her tr		Rain Young/Son 20a. Method of Disposition					w St. N.W	. wasni	20c. Location -		
ouise	Baltimore,	int of h	1 10	1 ☐ Burial 2 ☐ Cremation 3 ☐		late	Disposition (Na y, crematory or		^{сө)} 05-2		Alexand	-	WI, State
20	Ħ	iit. Partmer artmant injury		4 □ Donation 5 □ Other (Special21. Signature of Funeral Service Lice		Metr	opolita	n nd Addre	ess of Facility MAr				2
	Ba	Deparition of the popular of the pop		Do no maria	RAPP				St. N.W.				
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that can	used the death. Do n ch line.						1	Approximate Interval Between
		Pnysician		Immediate Cause (Final disease or condition	a Carci	lnoma of S	tomach						Onset and Death
		/Medical Examiner		resulting in death)		r as a consequence of		iam					
			P.	Sequentially list conditions,		Pulmonar		ISIII				-	
		uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events									
	ó	sician and burial-transit		resulting in death) Last	Due to (o	r as a consequence of	of):						
	3760,	ate be hysiciá ihe bu	Ilcal		d								
	Вох 68	entific fing p	Mec	IF FEMALE:	22a If year outs	ome of pregnancy							
	P.O. Bo	Physicien: The law requires that the death certificate be executed this certificete has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	th 2 Fetal death nt at time of death	3 □Ectopic 5 □ Other (s		y		Mor	e of delivery	y Day Year
		es that igned by be deta	by Ph	Part II. Other significant conditions	contributing to dea	ath but not resulting in	the underlying	cause giv	en in Part I.	23e. Did to	obacco use contr	bute to the	cause of death?
	of Vital Records,	equire: en sig ould b								1 🗆 Y	res 2□No	3 🗍 Probal	bly 4 🖺 Unknown
	000	ie law requ has been ge 2 shouk	Completed							24a. Was	an 24b. V	Vere autopa	sy findings available pletion of cause of
	Ä	The laste has page	Com							perfo 1 ☐ Yes	rmed? d	eath?	2□ No
	/ita	hysicien: Th nis certificete I director, pag	Be (25. Was case referred to medical examiner?					26. Place of Deat				
	of \	Physi this c	5	1 ☐ Yes 2 🛣 No 27. Manner of Death		patient 2 ER/Out	tpatient 3 🗆 C		ner: 4 ☐ Nursing Ho		dence 6 Other		
	no	ding h h. After funer	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of (Month	, Day Year) Ir	njury M	28c. Injur Wor 1 🗆	rk? Yes 2 □ No	200. Describe i	low injury occurre	,,,	
	Division	or Attenutive deat	Certification;	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	of Injury - At home, far g, etc. (Specify)				28f. Location (S City or Tox	Street and Number vn, State)	or or Rural i	Route Number,
	ш	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funera	edical Ce			pest of my knowledge sis of examination and							
		o the o the ornple	Mec	29b. Signature and title of certifier	and manne	o, stated.	25	c. Licens	se number		29d. Date signed	(Month, D	lay, Year)
		⊢ ≯ ⊢ ŏ		MEN	outer			D-17	874		05-25	- 05	
-				30. Name and address of person who	control ted cause	of death (Item 23a) (Type, Print)			1		_	
CR		U		S.M. Nayar, M.			nue Cot	age	City, MD	20722			
- 1		Sta Regist		31. Date filed (Month, Day, Year) MAY 9 1 200		gistrar's Signature	land.						

				ate of Maryland	d / Depa	artment o	f Health a	and Mer	•		5 10711
			State Registrar 1. Decedent's Name (First, Middle, Last)		Cel	tificate c	of Death		Reg Date of Death	l. No.	13/14
	Physici	an		Ion Wrott	C _m				Month	Day Year	
	/Medi		4a. Facility Name (If not institution, give street	Jay Wyatt,	Sr.	4h Cih, Tou	m, or Location of		June	4c. County of De	
4	Examir	ıer	Union Hospital of	f	2444	G / L	11	or Death		Cecil	atn
	Funeval		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	*	If Under 1 Ye	ear If Under	24 Hrs. 8.	Date of Birth		rthplace (State or Foreign
	Funeral Director		215-28-4767		Yrs.	Months Da	ays Hours		Date of Birth (Month, Day, Y uly 20,		rthplace (State or Foreign Country) aryland
	and		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary f she	ō	Maryland Cecil	E1	kton						1 ☐ Yes 2 🔀 No
	28a ncti	rec	10e. Street and Number			10f. Zip Cod	 de		100	. Citizen of What C	country?
	3a o	Funeral Director	7 Little John Drive			2192	1			United S	tates
	death	ner		as Decedent Ever in U.S med Forces? 19	S 13. V		of Hispanic Ori Cuban, Mexican	gin? (Specify	Yes or No-	14. Race - Am	erican Indian,
9	after or ite	E	1 Never Married 2 → Married 1	AYes 2 No 19		Yes 2 🛣			in, etc.)	Black, Wh	ite, etc.
93	ural',	d b	3 ☐ Widowed 4 ☐ Divorced Ÿe	ear or Dates:	02	103 2	140 Specify.			Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show evant. If a Medical Examinat the notified at	Completed by	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Deced (Give	lent's Usual Ockind of work do	ccupation one during mos itired)	t of working	16	b. Kind of Busines	s/Industry
121	then in	m	Elementary/Secondary (0·12) Co	oltege (1-4or 5+)		it Cutte				Retail	
2	filed with Hygiene Ithar thai		17. Father's Name (First, Middle, Last)		1100	- Outle		er's Name (Fi	rst Middle Ma	iden Sumame)	
an	be do do	o Be	Thomas Wyatt					inces M		, and a serial s	
<u>Z</u>	d 2 should be the and Menta it is marked traumatic events.	2	19a. Informant's Name/Relationship (Type, Pi	rint)	19b. Mailin	a Address (Str				City or Town, State,	Zin Code)
Maryland	12 th ar		Karen L. Wyatt/Daug							ryland 2	
ē,	1 a He am the		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of	f	June 6		c. Location - City o	
30	0 0 == =		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov `4 ☐ Donation 5 ☐ Other (Specify)			natory or other on Ceme		2005		nerry Hil	1, Maryland
Baltimore,	inite art		21. Signature of Funeral Service Licensee	1 -							
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			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death.	. Do not ente	er the mode of	dying, such as	cardiac or re	spiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dilated	Car	diory	coastl	C			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ence of):		0/19/1	7			a we
	Examiner		Sequentially list conditions. b	Myound	letis			(4 wks
17	pe is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):						·
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	res tha igned I be det	by	Part II. Other significant conditions contribution		Iting in the ur	iderlying cause	given in Part I.			.1	o the cause of death?
Records,	w require been si should b	Completed	Intra obdoning	sysus					1 🗌 Yes	2)≤N e 3 □ P	robably 4 Unknown
ec	e law has b	npie		-					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>E</u>		Cor							performe	d? death? No 1 ☐ Ye	s 2 No
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of	Phys	٠ <u>.</u>	1 162 5 140	1 Anpatient 2 L	R/Outpatient 28b. Time of		njury at			e 6 Other (Spe	ecify)
Division	Attanding It death. sctor: After by the funer.	tion	1 → Natural 5 ☐ Pending 2 ☐ Accident investigation	a. Date of Injury (Month, Day Year)	Injury	1	Work? 1 □ Yes 2 □ I		DOSCINDO NOW	injury occurred	
S	I or Attandi after death. Diractor: A i in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be 286	. Place of Injury : At hor	ne, farm, stre	et, factory, offi	ice	28f.	Location (Stree	et and Number or F	ural Route Number,
ă	Diri	Certification;	4 Homicide	building, etc. (Specify)	,				City or Town, S	State)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical ((Check only 2 Medical Examiner: C	To the best of my know	vledge, death on and/or inv	occurred at the estigation, in m	e time, date an ny opinion, dea	d place, and th occurred a	due to the caus t the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To tha complet	Med	29b. Signature and title of certifier	nd manner stated.		29c. Lic	ense number		29d.	. Date signed (Mon	th, Day, Year)
	- × - ŏ		· All all-	ingo		n.	20.00	190			
	~ x		30. Name and orderss of person who complet	ed cause of death (Item	23a) (Type: I	Print)			3		
	- 'A'		Alfred Pinone	1 Union	Hosi	nite!	106	BOW	SF E.	Ikton,	2005 mp 21921
3	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 0 2005	32. Registrar's Signatu	8 4	and the				-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10g per fh 844 6-13-05 vt
State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** WOLINSKI 200 VIRGINIA Am DORA /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford AIR Health MaRINEC If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/12/1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 F 90 217-60-2006 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a, State in than "natural", or items 23a or 28a-f show the Medical Examinativist by multiped at 1 ☐ Yes 2 No Bel Air Harford Director MD. 10g. United hat Country? 10e. Street and Number 10f. Zip Code Unitd States 21014 300 Sunflower Apt.155 Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Infortant: if Item 27 is marked other than "naturel", or Itel important: if Item 27 is marked other than "naturel", or Itel and yijury or other traumatic event, Ite Medical Examina and. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fisher Marie Maldeis Amelia Zeller George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bridgewater, Va. P.O. Box 48 Shirley Steger/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Air Mem. Gardens 6/9/2005 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bel 21. Signature of Funeral Service Li Andee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final luve **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed certificate 2 1 No or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 3 DOA 4 Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After : 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d Date signed (Month, Day, Year 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) **JUN 1** 0 2005

30. Name and address of person who completed cause of



death (Item 23a) (Type, Print)

		1	For State		of Maryland /	Depar		ealth and M	Mental Hy	giene	5 97 6
			Registrar I. Decedent's Name (First, Middle, La	ctl		Cert	ilicate of L	- Catiri	2. Date of Dea	Reg. No.	3. Time of Death
Ph	ysiciar		0	•	1 000				Month	Day	Year A M
//	ledica	il .	a. Facility Name (If not institution, give	AGET		070	4b. City, Town, or	Location of Death	1000	12 2000 4c. County of	f Death
Ex	amine				imber)		4b. City, Town, or	o	•		
			5. Social Security Number 6.5	OKS H	7. Age (In yrs. last b	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti	HARE	9. Birthplace (State or Foreign Country)
, Fun Dire				I □ M 25€ F	70	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year)	PANLAND
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death with the Maryland ms 23a or 28a-f show	ঝ		10a. State 10b. County		10c. City, Tov	vn or Loca	ation				10d. Inside City Limits
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h the	a not	Director	10e. Street and Number		اهو		10f. Zip Code			10g. Citizen of Wh	nat Country?
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036 ours after death with the Marylan ral', or Items 23a or 28a-1 show	SE LOS	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.S. orces?	13. W	as Decedent of His Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race Black	- American Indian, , White, etc.
م الله علوه	9	로	1 Never Married 25 Married	1 ☐ Yes If Yes, G	250 No ive		Yes 2⊠ No	Specify:		Specify:	. 311
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			17. Father's Name (First, Middle, Last)		201	- Annal -		ne /First Middle	Maiden Surname	10 cc
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Maryland Maryland d 2 should be fift th and Mental H 27 is marked out	renu	1	19a. Informant's Name/Relationship	Type, Print)		0	Address (Street a			- 60	tate, Zip Code) 310130
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Baltimore, ME Baltimore, Me permit. Pages 1 and 2 Department. Pl tenth a important: It tiem 27 is	or other treumatic event, If a Medical		20a. Method of Disposition 1 □ Burial 2⊠ Cremation 3 [Removal from	comet	ery, crema	tion (Name of atory or other place	1677 700	112		., 60
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Ball Ball Ball	any in		21. Signature of Euneral Service Lice	nsee		ZV	Name and Address	and on the same	4616x7-	1757 H. 18	3105C
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/Med			resulting in death)	Due to	o CARDIA o (or as a consequence RONAR	of):					
Exam			Sequentially list conditions.	b. (5)	RONAR'	A	RTERY	Lise	ASE		ten years
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760, te be executed	trans	аш	Cause (Disease or injury that initiated events resulting in death) Last	c							
760, te be execul ysician and			resulting in death) cast	Due to	(or as a consequence	or):					
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Division of Vital Records, P.O. Box 687 To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.	sae	Physician/Medi	IF FEMALE:								
Box Box	Su no	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnancy birth 2 ☐ Fetal deat		ctopic pregnancy			23d. Date Mont	of delivery h Day Year
O. E. Be dezi	of bed	200	1 □ Yes 20 No 9 □ Unknown	4⊟Preg 9⊟Unki	nant at time of death	5 🔲 (Other (specify)				
P.G	etac	5	Part II. Other significant conditions	antributing to	doub but not regulting	in the une	larhing cause give	n in Part I	23a Did to	obacco use contrib	oute to the cause of death?
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Son S	plno	ted	CHRONIC OBSIRUC	TIVE T	WIMONNE!	(L)	15/900 -		-	1	
as be	2 5	ble .							24a. Was autop	osy pr	ere autopsy findings available ior to completion of cause of
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#368 Vital Records,	ctor,		25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)	
Tysic on mysic on mis one	dire	0	1 Yes 2 No	Hospital:	Inpatient 2 EPVC	utpatient	3□ DOA Othe	r: 4 ☐ Nursing H		dence 6 Other	
of of of or this ter this	nera		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Moi	of Injury 28b. oth, Day Year)	Time of Injury	28c. Injury Work	at ?	28d. Describe h	now injury occurre	d
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IN IN IN IN IN IN IN IN IN IN IN IN IN I	by 1	ti Ei	3 ☐ Suicide 6 ☐ Could not to determined	200. Flat	e of Injury - At home, t ding, etc. (Specify)	arm, stree	et, factory, office		28f. Location (S City or Tox		r or Rural Route Number,
Division of Division of House after death. 124 hours after death. 124 hours after death. 124 hours after death.	led ir	Č						la la			
dsol houn	aly fil	cai	29a. Certifier 1 Certifying P	miner: On the	ne best of my knowledg basis of examination a	e, death ond/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the or rred at the time,	cause(s) and man date and place, ar	ner as stated. Id due to the cause(s)
the the	plete	Medical	one)	and ma	nner stated.						(Month, Day, Year)
St. St. St.	COM	2	29b. Signature and title of certifier	0:1	-00.0		29c. License				
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di	1		30. Name and address of person who				rint)			A 1/1 A 1/1	2
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	State		31. Date filed (Month, Day, Year)		Registrar's Signature						
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ls.					OR	GINA	L				== == == == == == == == == == == == ==

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 645 Olga Alexandrovich /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Birthplece (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Hours **Funeral** Days 1 ☐ M 2 ☐XF Yrs. 79 25, 1925 New Jersey Director 150-16-7419 Usuel Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "naturel", or items 23s or 28s4 sho other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director New Jersey Monmouth Keansburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number ALEXANDROVICA 07734 170 Central Ave. USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: ٥ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Hygiena. Executive Assistant Securities 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health end Mantal Important: If Item 27 is marked o any injury or other traumatic eve Walter (nmn) Alexandrovich Martha (nmn) Dubutoka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5802 Meadowview Ave., North Pergen, NJ 07047 of Disposition (Name of Date 20c. Location - City or Town, State Marge DelleDonna / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-16-05 Fairview, New Jersey Fairview Cemetery 21. Signature Funeral Service Licensee 22. Name and Address of Fecility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the diseese, or compliceti shock, or heart failure. List only one Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner edical Certification: To Be Completed by Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobscco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 212NO 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) 25. Wes case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Aftar this nours after death. neral Director: After this y filled in by the funeral d 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 4 T Homicide within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completaly (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier

State Registrar 6

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Day, Year)

mn

32. Registrar's Signature

DHMH 16 Rev 6/95

			For State Registrer	State of	Marylan	•	artmen <i>rtificat</i>					jiene () eg. No.	05	19718
	Physici	20	1. Decedent's Name (First, Middle								2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic				thoff						June 8	2005		6:00 PM M
	Examin	er	4a. Facility Name (If not institution,	-	er)		1		Location				inty of Death	
			4334 Gene Hemp 5. Social Security Number		Age (In vrs	last birthday)		Jeiie 1 Year	erson If Under		B. Date of Birth			ck County
н	Funeral Director		220-12-5660	1□M 2√1xF		30 Yrs.	Months	Days	Hours	Min.	(Month, Day	Year) 1924		place (State or Foreign intry) vland
			Usual Residence of Decedent								CC. J.	1724		
	show	_	10a. State 10b. County	1 . 1 . 0		ty, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes INNo
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	72 hours eiter deeth with the Marylend natural', or Items 23s or 28s-f show dical Examinar must be molified at	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	l.S. 13.	Was Dece			igin? (Spec	ifv Yes or No-	14.1	Race - Ameri	
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03	ral', c	i by	% Widowed 4 □ Divorced	If Yes, Give Year or Date	9S:		1 □ Yes ∑	Z & J No	Specify:			Spe	ecify: Wh	nite
21215-0036	n 72 hours natural',	Completed	15. Decedent (Specify only highes	s Education t grade completed)		(Give	dent's Usua kind of wo	rk doné a	urina mos	t of working	9	16b. Kind o	f Business/Ir	ndustry
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an	ld be entai ked c	To Be	James Donaghy							Nina	Fuss			
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Σ	and 2 salth a n 27 i		Richard Monroe	(Son)					Roa		ffersor			21755
Baltimore,	of He of He Miten		20a. Method of Disposition 1XX9urial 2 □ Cremation	3 □Removal from St		Place of Disponentery, cre-	matory or o	ther place		Da			on - City or T	
Ë	. Pag tment tent: jury c		`4 □Donation 5 □ Other (Sc	ecify)	Mt	. Zior				6/11/	2005	Park	ton, N	Maryland
Bai	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre ance.		21. Signature of Funeral Service	(icensee		2	2. Name an Bur	nd Addres Lec-H	s of Facili leuss	Seit	z Funer Itimore	al Ho	me, Ir	ıC.
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			lmmediate Cause (Final	only one cause 🍿 eac	th line.									Interval Between Onset and Death
	Physician /Medical	8 11	disease or condition resulting in death)	a. Due to (or	1-ech	vience of):	aov	tic	an	reu	n'in			
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	n *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								
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8760	physic the t	dlcal		d										
9 x	leeth certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy						23d	Date of deliv	erv
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	de de	by P	Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the u	ndertying c	ause give	n in Part I		23e. Did to	bacco use o		the cause of death?
ord	w requires been sign should be	ted	- chronic o	6, huchr.	e a	ing	dise	01-8			1 E Y	es 2 N	o 3 Pro	bably 4 Unknown
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Vita	Physician: The this certificate al director, pages	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or			
of		To To	1 Yes 2 No	1 Inp		28b. Time o					e 5 Aeside			<i>fy</i>)
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N N	Attandiler death.	ifica	3 Suicide 6 Could r	ot be ned 28e. Place or	f Injury - At h	ome, farm, st	reet, factor	y, office		28	of. Location (S City or Town		mber or Run	al Route Number,
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	To the Hospitel or Attandi within 24 hours after death. To the Funarel Director: A completely filled in by the fu	ledical	(Check only 2 Medical 8	g Physician: To the b exeminer: On the bas	is of examina	owledge, deat ation and/or in	h occurred ivestigation	at the tim	e, date ar pinion, dea	nd place, ar ath occurred	nd due to the c d at the time, d	ause(s) and ate and pla	manner as s	stated. to the cause(s)
	ithin ithin	Med	one) 29b. Signature and title of certifier	and manne	i Stateu.		290	c. License	number		2	9d. Date si	ned (Month,	Day, Year)
	+ 3 + 8				4	1		DL	70	06				2005
	0		30. Name and address of person	who completed cause	of death (Iter	m 23a) (Type.	Print)	400	ven	Mu	-owie		/ /	
(16 Aberdee			berd					015			
	Sta		31. Date filed (Month, Day, Year)	32. Reg	gistuer's Signa	ature	1							
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Edna Blue 0651 M June 9 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Samari If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 12-8-1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2**X**F 241-24-8417 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1XYes 2 No Director MD Station lurners 10g. Citizen of What Country? hestnut 21222 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, tre Magnes. Elementary/Secondary (0-12) College (1-4or 5+) ssembler Glen L. Martin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Addison arrie McArthur)ohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222. 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD
ate 20c. Location - City or Town, State Mickey/Niece Cove Rd. Deborah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State -butus Mem. Pk 6-14-00 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility James A. Morton & Sons F. H. Inc 21. Signature of Funeral Service Licensee Laurens St. Battimore, MD21 1701-31 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ventaievlan /Medical Due to (or as a consequence of): Examiner Cardiomyona Yrar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DISTECT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 200 No 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 43386 wos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Baltiment, MA 21217 1 toward Daniel R 1714 EUKen 31. Date filed (Month, Day, Year)
JUN 1 4 2005 Registrar's Signature State Registrar

	-	For State Registrar	State	of Marylar		artment of F		nd Mental	Hygie Reg	4 U	05	19720
Physicia /Medica		1. Decedent's Name (First, Middle, Lena		OWN		-		2. Date Mont		Day 9 20	_{Үөаг} 005	3. Time of Death
Examine	er	4a. Facility Name (If not institution, Ivy Mano 5. Social Security Number			last birthday)	4b. City, Town, o E111 If Under 1 Year	cott_C	City	of Birth		oward	
Funeral Director		139-34-9290 Usual Residence of Decedent 10a. State 10b. County	1□ M 2 X F	97	Yrs.	Months Days	Hours	Min. (Mon 8-	of Birth th, Day, Y	907	Cour	Russia
tha Maryia 28e-f show	ector	26.1	Howard	}	llicott				100	. Citizen of W		0d. Inside City Limits 1 ☐ Yes 2 █️XNo
aath with	Funeral Director	2928 Normandy		cedent Ever in U	18 13 1		21043	n2 (Specify Vac		USA	A	can Indian,
"natural", or items 23a or 28e-f show	2	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed I 1 _ Yes If Yes, 0 Year or	Forces? 2. ∰ No Bive		Vas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Puerto Rican, et		Specify.	k, White,	etc. Thite
and 2 should be filed within 72 hours after death with the Maryland Health and Manial Hygiene. Health and Manial Hygiene. Item 27 is marked other then "natural", or Items 23a or 28e-1 show other traumetic event, It & Healts. Examination is the marified at	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12th grade	t grade completed	(1-4or 5+) N/A	(Give	lent's Usual Occup kind of work done DO NOT use retired Legal S	during most o d)	3	R	b.Kind of Bu lobert Law Fi	Loui	dustry S Brown
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Tand 2 st Haalth and tam 27 is n		19a. Informant's Name/Relationsh Marilyn Binder 20a. Method of Disposition			923	ng Address (Street 1 Snow S sition (Name of natory or other place)	hoe La		ımbia		1045	·
t. Paga rtment o rtant: If		1 ▼Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	ecify)	Jaio	th Isr	ael Cem Name and Addre		6-12-200 March	05 W	oodbri		
parmi Dapa Impo any ir		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the deal	th. Do not ent	4300 er the mode of dyin	Wabasl ng, such as ca	h Avenue	Bal	to, Md	212	Approximate Interval Between
cata ba axecuted physician and the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a consection of or as a consection or a consection of or a consection of or a consection of or a cons	Juence of): 1 name	ic obsiders	7	ful a	•	renj O	lis	Onset and Death
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To the Hospital or At within 24 hours after To the Funeral Dirac complately filled in by	Medical	one)	and ma	nner stated.	ation and/or inv	estigation, in my o	pinion, death	occurred at the	time, date	and place, a	nd due to	the cause(s)
V		30 Name and address of person v	vgo completed ca	use of death (Iter	m 23a) (Type,	DS Printy 11	10870	0	J	une 1	MI	2005
State Registra	e r	30 Name and address of person v 31. Date filed (Month Day Yaar)	2005 32	Aegistrar's Signa	B Ago	- Sen	und	cen	wy	me	- L	,010-1

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22, LOIS WELCH BEDWELL MAY 2005 12:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE 560R505 FUTURE CARE PINE VIEW NURSING HOME CLINTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M Director 149-03-1511 89 JUNE 30, 1915 IOWA Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits 28a-1 show ir Itams 23e or 28e-f show 1 1 Yes 2 No Director VIRGINIA ALEXANDRIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with innent of Health and Mental Hygiene. 6347 EIGHTH CIRCLE 22312 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: WHITE Specify δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental P UNOBTAINABLE UNOBTATNABLE 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN DOUGLAS BEDWELL 6347 EIGHTH CIRCLE, ALEXANDRIA, VIRGINIA 22312 Mitem 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page: Department of Important: If any Injury or any Injury or o 6-14-05 NATIONAL CREMATORY FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licensee DEMAINE OF UNERAL CHAPEL ianos Lerio 5308 BACKLICK RD., SPRINGFIELD, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final **Physician** CARDIOPULMONARY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner END STAGE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran ARTIAL FIBRILATION resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical CANCER OF BREAST the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 KUnknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t the Hospitel or Attanding 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No Director: I 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05-26-2005 D 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 OLD BRANCH AVE SUITE 409 CLINTON, MD 32. Registrar's Signature State °2005

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			F	State of Maryland /	Department of Health and N	-	•	
		•	1 - State Registrar	,	Certificate of Death	Reg. N	2005	19722
П	Dhysisi		1. Decedent's Name (First, Middle, Last)	D D		2. Date of Death	ay Year	3. Time of Death
	Physicia /Medic		Young	Bog Bacq		June 13	2005	02:42 AM
	Examin	er	4a. Facility Name (If not institution), give s	treet and number)	4b. City, Town, or Location of Death		c. County of Deat	h
	Funeral		5. Social Security Number 6. Sex		irthday) ff Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		220-23-7864 A	M 2□F 82	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year 7-26-2	2 500	hplace (State or Foreign untry)
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c City Toy	wn or Location			10d fasida Citat imita
	Maryli f sho	o	MD	100.00,7	BALTI MORE			10d. fnside City Limits 1
	r 28a-	rect	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Co	untry?
	death with the Maryland ms 23a or 28a-f show	Funeral Director	11 W. 20th S	H. Apt. 10-	J. 21218		USA	
	after death w or Items 23a	uner		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
50	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	hite.
-00-C	filed within 72 hours after death with the Marylan Hygiene. Hygiene. Hygiene there is natural; or items 23a or 28a-f show int, it is Medical Exacilities at ant.		15. Decedent's Educ	cation 16a	a. Decedent's Usual Occupation	16b.	Kind of Business/l	Industry
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7	be filed withly ital Hygiene. od other than event, ire M	O	17. Father's Name (First, Middle, Last)		Selt caployed		as st	ation
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	shoul nd Me mark	ř	19a. Informant's Name/Relationship (Type		b. Mailing Address (Street and Number or Rur	NOWN Pal Route Number, City	or Town, State, 2	(ip Code)
Ž	and 2		Youn Sik Bac	20 11	315 South Dahi	la Ct. Be	1 Air M	D 21015
ore	ges tof He		20a. Method of Disposition 1 Ø Burial 2 □ Cremation 3 □ R		of Disposition (Name of ery, crematory or other place)	Date 20c. I	Location - City or	Town, State
Бапппо	t. Pag tment rtant:	1	`4 ☐ Donation 5 ☐ Other (Specify)	Meade		5-05 61	Kridge	MD
ם מ	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service License	2 sto	22. Name and Address of Facility	LP. TIMOR	SIUM M	DZIOB
			23a. Part1. Enter the disease, or compli	cations that caused the death. Do	o not enter the mode of dying, such as cardiac		RHLOCK	CMATTONCTA Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition					Interval Between Onset and Death
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<u> </u>	cate be executed bhysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	e of):			
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j.	the de	Physician/M	1 Yes 2 No 9 Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)			
7	w requires that the death certific been signed by the attending F should be detached for use as	by Pt	Part II. Dther significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
coras,	equire en sig ould b					1 ☐ Yes 2	2 □ No 3 □ Pro	obably 4 Honknown
ပ္	B 25 G	Completed				24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
	The ate	Соп				performed? 1 ☐ Yes 2 ☑ N	death?	21 No
N I I I	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:		h Check onl one		
ō	g Phys er this eral dii	\vdash	1 Yes 2 No	28a. Date of friury 28b.	Outpatient 3 DOA Other: 4 Nursing Ho Time of Injury at Work?	me 5 Residence 28d. Describe how in the	6 ☐Other (Specury occurred	ify)
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DIVISION	r Attencter death	ertification	3 Suicide 6 Could not be determined	28e. Pface of Injury - At home, f building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, Star	nd Number or Ru. te)	ral Route Number,
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer) Me	280. Signature and title of certifier	30000	29c. License number	29d. D	ate signed (Month	, Day, Year)
		1	Kicken David	o. M	A T242894	a Ju	ne 12	305
	11		30. Name and address of person who co	mpfeted cause of death (Item 23a)	A T2438940 Orial Hospital Bo		:	
L	20	† 0	31. Date filed (Month, Day, Year)	32 Registrar's Signature	orial Hospital Bo	altimore,	MD	
	Sta Registr		JUN 1 4 20	05	Grante)			

Decedent's Name (First, Middle, Las Nick Barr Aa. Facility Name (If not institution, give Howard County Ger	•				te of Death		3. Time of Death
4a. Facility Name (If not institution, give	103			May	0.1	ay Year 2005	0025
Howard County Cor	street and number)		4b. City, Town, or Locat			c. County of Death	
, mowara coulity Gel	neral Hosp	ital	Columbia			Howard	
5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year If Un	der 24 Hrs. 8. Da	ite of Birth onth, Day, Year		place (State or Fore
216-36-8824	M 2□F	86 Yrs.	Months Days Hou	urs Min. (Mo	1y $25,1$	918 Ukra	aine
Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town or L	neation				10d. Inside City Lim
Maryland Baltimo	200		sville				1 ☐ Yes 21
	716	Caton			10a C	itizon of Mhat Cou	
				00	109. 0		•
	12. Was Decedent E	Ever in U.S. 13.			es or No-		
	1 ☐ Yes 2 ☑ N	lo			etc.)	Black, White,	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Spe	cify:		Specify: Wh:	ite
		16a. Dece	dent's Usual Occupetion	most of working	16b.	Kind of Business/In	ndustry
Elementary/Secondary (0-12)		+) life.	DO NOT use retired)	nost of working			
12		Elec	trician		Un	iv. of Ma	ryland
17. Father's Name (First, Middle, Last)			18. M	other's Name (First,	Middle, Maide	n Sumame)	
Ivan Tovstyk			M	latrona (Jnknown		
							o Code)
	es (Wife		and the lateral property of th	The same of the sa			
	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date	20c. l	Location - City or To	own, State
		Loudon P	ark	6-2-200)6 Ba:	ltimore,	Maryland
21. Signature of Funeral Service Licens	90/1	2	2. Name and Address of F	acility			
Demand	Kala	rested 1	630 Edmonds	n Ave.	atonsv	ille, Mar	yland 2
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.						
	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	2 ☐ Fetal death 3 [Market and the second	23d. Date of delive Month	ery Day Year
			inderlying cause given in P	art I. 23		\ \ \ \	he cause of death
					. 146		
			SEASE		autopsy	prior to co	opsy findings avail Impletion of cause
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1 Statural 5 Pending	(Month, Day	Year) Injury	Work?		3001100 11010 11111	ary occurred	
E C / tooldont		iry - At home, farm, st (Specify)	reet, factory, office	28f. Loc Cit	cation (Street a ty or Town, Sta	and Number or Rura te)	al Route Number,
29a. Certifier 1 Certifying Phy (Check only one)	iner: On the basis of	examination and/or in	th occurred at the time, date overstigation, in my opinion,	and place, and dur death occurred at the	e to the cause(s	s) and manner as s nd place, and due to	stated. o the cause(s)
29b. Signature and title of certifier	1 1		29c. License numb	per	29d. D.	ate signed (Month,	Day, Year)
Jus.	tus !	1	170	15111		TUNE	.) ~ .
30. Name and address of person who co	completed cause of de	eath (Item 23a) (Type	Print)	11174		2010	120
Tri triangle to the second sec	RRY E	IND	Print)	Ela	- 501		- c T
	10e. Street and Number 429 Neepier Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest graves) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Ivan Tovstyk 19a. Informant's Name/Relationship (7) Genevieve F. Barried 20a. Method of Disposition 1 Burial 2 Cremation 3 Content of the Content of Specify 21. Signature of Funeral Service Licenty of the Content of Specify 23a. Part1. Enter the disease, or composition of the Content of Specify 23a. Part1. Enter the disease, or composition of the Content of Specify of the Content of Specify 23a. Part1. Enter the disease, or composition of Specify	10e. Street and Number 429 Neepier Road 11. Marital Status 12. Was Decedent & Armed Forces? 1 Yes 2 20 Never Married 2 Married 1 Yes 2 20 New Year or Dates: 1 Yes 2 20 New Year or Dates: 1 Yes 2 20 New Year or Dates: 1 Yes 2 20 New Year or Dates: 1 Yes 2 20 New Year or Dates: 1 Yes 2 No 1 Yes 2 No 2 New Year or Dates: 1 Yes 2 No 2 New Year or Dates: 1 Yes 2 No 2 New Year or Dates: 1 Yes 2 No 2 New Year or Dates: 1 Yes 2 No 2 New Year or Dates: 1 Yes 2 No 2 New Year or Dates: 1 Yes 2 No 2 New Year or Dates: 1 Yes 2 No No	10e. Street and Number 429 Neepier Road 11. Marital Status 1	106. Street and Number 429 Neepier Road 11. Marital Status 1	106. Street and Number 429 Neepier Road 12. Was Decedent Ever in U.S. 13. Was Decedent Origin? (Speeify? If Yee, Speeify Cubic Plant States 12. Was Decedent Ever in U.S. 13. Was Decedent Origin? (Speeify? If Yee, Speeify Cubic Plant States 12. Was Decedent Ever in U.S. 13. Was Decedent Origin? (Speeify? Speeify? Speeify? Was Green States 12. Was Decedent States 12. Was Decedent States 12. Was Decedent States 12. Was Decedent States 12. Was Decedent States 13. Was Decedent States 12. Was Decedent States 12. Was Decedent States 13. Was Decedent States 12. Was Decedent States 13. Was Decedent States 12. Was Decedent States 12. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States 13. Was Decedent States	10s. Street and Number 429 Neepier Road 11. Marital Status 12 Was Decedent Ever in U.S. 11 Never Marited 2 Married 3 Wicknewd 4 Divorced 11 New Marital Status 12 Was Decedent of Maganic Origin' (Specify New or No-Marited New Origin) 12 Was Decedent of Maganic Origin' (Specify New Original New Origin) 13 Was Decedent of Maganic Origin' (Specify New Original New Origin) 14 Specify of Wash Original New Origin (Specify New Original New Origin) 15 Decedent's Education (Specify only Impress grade Completed) 16 Decedent's Hutal Occupation 17 Father's Name (First, Middle, Mate) 18 Mother's Name (First, Middle, Mate) 19 National Name (First, Middle, Mate) 10 National Name (First, Middle, Mate) 10 National Name (First, Middle, Mate) 10 National Name (First, Middle, Mate) 10 National Name (First, Middle, Mate) 10 National Name (First, Middle, Mate) 11 National Name (Firs	10f. Zip Code 10g. Cilizan of What Code 10g. Cilizan of What Code 10g. Cilizan of What Code 10g. Cilizan of What Code 11g. Markal Status 12 Was Decedent Ever in U.S. Amed Forces? 13g. Was Decedent of Fespania Cright? (Seach) Yes or No. 14 Reac - Amed Forces? 11g. Was Decedent of Fespania Cright? (Seach) Yes or No. 15g. Reach Amed Forces? 11g. Was Decedent of Fespania Cright? (Seach) Yes or No. 15g. Reach Amed Forces? 11g. Was Decedent of Fespania Cright? (Seach) Yes or No. 15g. Reach Amed Forces? 15g. Reach Amed Forces. 15g. Reach Amed Forces. 15g. Reach Amed Forces. 15g. Reach Amed Forces. 15

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T.	Examin		4a. Facility Name (If not institution, give	/	4b. City, Town, o	or Location of Death	/	4c. County of Death	
		4	MERCY MR JIC 5. Social Security Number 6. Se		st birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign	_
6). A. A.	Funeral Director		Usual Residence of Decedent	M 20 F	Yrs. Months Days	Hours Min.	Modith Day, Ye	MARYIAND	_
	/land		10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits	
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	th the	lred	10e. Street and Number	AP+ J	10f. Zip Code	_	10g.	Citizen of What Country?	_
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	tems	n ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No	. 13. Was Decedent of F If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: RIAC A	
2-003	within 72 hours after ene. than "natural", or Ita na Medical Example		15. Decedent's Ed	ucation	16a. Decedent's Usual Occup	pation	168	b. Kind of Business/Industry	
215	hin 72 In "na	plet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of work d)	ing		
21	giene giene er the	Completed	Liononiary/occordary (o 12)	School (1 set sty					
<u>p</u>	should be filed within 72 hours after death with the Marylan of Mental Hygiens. Tarked other than "natural", or Itams 23a or 28a-1 show marked other than "natural", or Itams 23a or 28a-1 show marked other, than "natural", or Itams to notified at marked ovent, ita Medical Evantar must be notified at	Be	17. Father's Name (First, Middle, Last)	RA	1140	18. Mother's Name	e (First, Middle, Mai	den Sumame)	
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Maryland	s 1 and 2 should 1 Health and Men Item 27 is marks other traumatic		19a. Informant's Name/Relationship (T	Ly FATHER				ity or Town, State, Zip Code) APT	-
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Ba	Depart Depart Import any inj once		18 dison M.	Paking	Sterling A	Ashton Sch	wab Funer	cal Home, Inc.	
			23a. Part1. Enter the disease, or composition of the shock, or heart failure. List only of	ilications that caused the death.	Do not enter the mode of dying	ng, such as cardiac	or respiratory arrest.	Approximate Interval Between	
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90	e be executed /sician and e burial-transit	alE		550 10 (01 21 2 001000400				\rightarrow	
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Вох	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance				23d. Date of delivery	
m.	death e atte rd for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fetal d 4☐Pregnant at time of dea		y 		Month Day Year	
P.O.	that the dened by the and detached f	hys	9 Unknown	9 Unknown			=		
	res tha igned be det	by P	Part II. Other significant conditions co	intributing to death but not result	ting in the underlying cause give	ven in Part I.		co use contribute to the cause of death?	
ord	w require been si should t						1 ☐ Yes	2 No 3 Probably 4 Winknown	
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ot	Phys this al dir	. To	1 ☐ Yes 2 No 27. Manper of Death	Vinpatient 2□E	PVOdtpatient 3 DOA		me 5 Residenc 28d. Describe how	e 6 Other (Specify)	_
o	ding P h. After funer	tlon	Natural 5 Pending	(Month, Day Year)	Injury Wo	rk?]Yes 2 □ No	200. Describe now	infairy occurred	
Division of	Attending Physician: Ir death. ector: After this certifice by the funeral director.	flca	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, street, factory, office			t and Number or Rural Route Number,	-
á	al or after	Certification:	4 Homicide	building, etc. (Specify)			City or Town, S	itate)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral			ysician: To the best of my know				e(s) and manner as stated. and place, and due to the cause(s)	_
	the H nin 24 the F the F	Aedical	one)	and manner stated.					
	To To	Σ	29b. Signature and title of certifier	Marital	29c. Licens	se number	29d.	Date signed (Month, Day, Year)	
			W. Fr) /(sunatul	J. 1 1 1 1 9	0/15	4	10/05	_
			30. Name and address of person pro-	completed cause of death (Item 2	(Type, Print)	0/200 7	Solha	and and	
	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	1 47 16 VI /	· · · · · · · · · · ·			_
14	Registi		JUN 1 4 2005	Men &	Sparke				

amend item/4c, per/M), C844, 6/15/05 II State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Helen Busche 10:30p [™] June 11 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Gounty of Deathery Examiner 9141 Goshen Valley Drive 20882 Laytonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F Yrs. Director 202-12-4377 80 Pennsylvania April 18,1925 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 1 No Maryland Montgomery <u>Lavtonsville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 Completed by Funeral 9141 Goshen Valley Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed nent of Health and Mental Hyginnt: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Mark Cackovic Katherine Rogina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tre 9141 Goshen Valley Road, Laytonsville, MD 20882 Richard Busche/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ō Department of Important: if any in ury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 6/16/2005 Silver Spring, Maryland 21. Signature of uneral Service Licens 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se Physician DS15 disease or condition resulting in death) wee /Medical Due to (or a a consequence of): Examiner comve Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine disease Cause (Disease or injury that initiated events resulting in death) Last transit The law requires that the death certificate be executed vasculaphera Due to (or as a consequence of) the burial-Box 68760 Physician/Medical as esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown à signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Lnow 1☐ Yes 2☑ No Division of Vital 2 No 1 Yes Physician: director 25. Was case referred to_medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 Z atural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: in 24 hour.
the Funerel Directory filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel within 2 To the 29b. Signarate and title of certifie 29d. Date signed (Month, Dav. Year) 956 awy vodece June 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dawn Broderick MD 18109 Prince Philip Drive # 275 Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State Registrar

Certificate of Death See Note Condemn Name First Models Law James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Burdette James Javes on Javes Jave				for State	State of M				nd Mental Hy	giene	
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Physician Medical Examiner Part College Physician Part College Part Par				23a. Part1. Enter the disease, or complic	cations that caused	d the death. Do not er	ter the mode of	dge Koac dying, such as c	1, Damaset ardiac or respiratory ar	ıs, Marylaı rrest,	nd 20872 Approximate
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29c. License number 29d. Date signed (Month, Day, Year) June 11, 2005 30. Name and address of reson who complete cause of death (Item 23a) (Type, Print) Patryce A. Toye MD 4565 Hemlock Cone Way, Ellicott City, Maryland	<u> </u>	hysic his ca	0	1 PYes 2□ No	ospital: 1 🗌 Inpatie	ent 2 ER/Outpatie	nt 3□ DOA	Other: 4 🗌 Nurs	sing Home 5 Thesic	dence 6 □Other (Sp	ecify)
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30. Name and address of Prson who completed cause of death (Item 23a) (Type, Print) Patryce A. Toye MD 4565 Hemlock Cone Way, Ellicott City, Maryland	69	6		1 atmost	17~ 1	\sim	D	3147	3	June 11. 2	005
Patryce A. Toye MD 4565 Hemlock Cone Way, Ellicott City, Maryland State Registrar Patryce A. Toye MD 4565 Hemlock Cone Way, Ellicott City, Maryland State Registrar	1	•		30. Name and address of *rson who con	7.2		Print)				
State Registrar 31. Date filed (Month, Clay) New 1 4 2005 32. Registrar's Signature	2			Patryce A. Toye M	D 4565 He	mlock Cone	Way, E	llicott	City, Mary	yland	
				31. Date filed (Month, Lay Year) 4 2	.005 32. Registr	ars Signature	parte				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Elizabeth Ann Barr June 12 2005 8:20a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Director Yrs. 233-60-0465 68 8, 1937 April West Virginia Usual Residence of Decedent withIn 72 hours after deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Walkersville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9946 Kelly Road 21793 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: by Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be 18. Mother's Name (First, Middle, Maiden Sumame) James Harry Dillow Clemantine Hagerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5233 Golden Eagle Pkwy, Brighton, CO 80601

ca of Discosition (Name of 20c. Location - City or Town, State Susan Barr/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State June 14,05 ' 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium Inc. Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, have been also been accessed. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disa to for as a nonsequence of) The law requires that the deeth certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Yes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) mo June 13, 2005 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sajjad Aziz MD 801 Toll House Ave # C3 Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2005 Registrar

		1	For State	State of Maryland / Dep	partment of Health an ertificate of Death	d Mental Hygie	2000 10120
	g		Registrar 1. Decedent's Name (First, Middle, Last			2. Date of Death	3. Time of Death
	Physicia		Rose B.	Brown		Supe	10 2005 8 304 M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of E	Death	4c. County of Death
			2714 Oakley	Are	Baltimore		NA
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last birthda M 2 XF 7G Yrs.	y) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent			1 13	
	rylan		10a. State 10b. County	10c. City, Town or			10d. Inside City Limits 1
	8e-1 s	Director	Md N/x	Bultim	ore	1.2	
	with th	Dir.	10e. Street and Number	1.	10f. Zip Code	10g.	. Citizen of What Country?
	ns 234	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No-	14. Race - American Indian,
0	ir iten		1 Never Married 2 Married	1 ☐ Yes 2 ▼No		Puerto Rican, etc.)	Black, White, etc.
8	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importents If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other treumatic event, the Medical Ever in an intelliged at once.	d by	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
2	72 h "natu	Completed	15. Decedent's Edi (Specify only highest grad	le completed) (Gi	cedent's Usual Occupation ve kind of work done during most of DO NOT use retired)	f working 16	b. Kind of Business/Industry
12	withir ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	nurse		Medica!
aryland 21215-0036	filed Hygi other ent, L	ക	17. Father's Name (First, Middle, Last)	1		Name (First, Middle, Ma	iden Sumame)
a	ould be filed withi Mental Hygiene. wrked other than satic event, ILe M	To B	James T	Youtgomeny	Iren	re Tinkler	/
ary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (T		illing Address (Street and Number of	or Rural Route Number, C	1 1
Σ	and 2 ealth m 27 i		Kuth Davenpo	27	16 Cakley An	Date 20	10 pe, bd. 2/215
Baltimore,	Pages 1 nent of H int: If iter iry or oth	Š	20a. Method of Disposition 1 Surial 2 Cremation 3	cemetery o	position (Name of rematory or other place)	Date 20	c. Location - City or Town, State
Ē	t. Pa rtmen rtent: njury		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentary 	000010	Name and Address & Smilling	ine 15, 2005	salamone, Ma
Ba	Departi Departi Importi any inj once.		21. Signature of Pulletan Service Licent	Directory !	artism C. pour	gla s fun	eral Service P.A.
			23a. Part1. Enter the disease, or comp	lications that caused the death. Do not one cause on each line.	enter the mode of dying, such as ca	rdiac or respiratory arrest	Approximate Interval Between
	Physician		Immediate Cause (Final	one cause on each line.	21:11 1.8	X	Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a consequence of):	1-0,41 2/1/24	Bhan	Thelvehoupo
ı	Examiner		Sequentially list conditions,	b. Hyper 1	ension		Tox years
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
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8760,	icate be executed physician and s the burial-transit	dical E	l	d.			
9	death certificate be executed the attending physician and ad for use as the burial-transit	ledic		Q			
Вох	eath certific attending p	M/M	23b. was decedent pregnant	23c. If yes, outcome of pregnan¢y 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
	e deat he att	by Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		5 Other (specify)		Month Day Year
P.O.	that the de led by the a detached f	Phy		ontributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobac	cco use contribute to the cause of death?
	gr gr	d by	Tatti. Other significant conditions of	STRIBUTING TO GOULT BUT NOT 1000KING IT IT	o and onlying daddo given in the arm.	1 ☐ Yes	
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Re	The lav	шс				autopsy performe	prior to completion of cause of death?
tal		Be Co	25. Was case referred to medical		26. Place o	1 ☐ Yes 2 L f Death (Check only one)	No 1 ☐ Yes 2 ☐ No
	S S	To B		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		ing Home 5 K Residence	ce 6 Other (Specify)
0 0	ng Ph fter th neral		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time	e of 28c. Injury at Work?	28d. escribe how	
Sio	Attending r death. ector: After y the fune	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		et and Number or Rural Route Number,
Division of	or At	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S	State)
	Hospital or Attend 24 hours after death Funerel Director: etely filled in by the		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowledge, d	eath occurred at the time, date and	place, and due to the caus	se(s) and manner as stated.
	To the Hospital or Attending Phymitin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral.	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death	occurred at the time, date	and place, and due to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	\	29c. License number	_	. Date signed (Month, Day, Year)
)	$\langle 1 \rangle$		MINI	}	103770	18 0	une 14, 2005
6	1		D.1 721 (V	completed cause of death (Item 23a) (Ty	pe, Print)	a Sex so	Une 14, 2005 Bettimen 12,213
4	C+	ate	31. Date filed (Month, Day, Year)	70 7435 Wal	welvesen INE	NO SOIL DE	1521 11m Dre 16 1/2121)
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		-	. 101	epartment of Health and Me Certificate of Death	ental Hygiene	-6002	9729
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Da		3. Time of Death
н	Physicia /Medic		Ellen Jane Bittle		June 13	2005	5:20 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	. County of Death	
ı		н	2601 Garrett Road	White Hall		Baltimor	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, MAR 28, 1	9. Birthplace Country)	
	Director		214 40 7777	s.	MAR 28, 1	945 Maryl	.and
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location		10d.	Inside City Limits
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	the P	Director	Maryland Baltimore	White Hall	10g. Ci	itizen of What Country	?
	with 3a or	Ö	2601 Garrett Road	21161		USA	
	ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spec	ify Yes or No-	14. Race - American	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then *netural', or items 23e or 28e-f ehow eny injury or other traumatic event, I'te Modical Examiner must be notified at once.	þ	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☑ No Specify:	ican, etc.)	Specify: White, etc.	
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7	ad wi	Co		e Economics Teacher	· · · · · · · · · · · · · · · · · · ·	ublic Schoo	ıls
lud	be fill d oth	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	n Sumame)	
$\frac{8}{2}$	nould I Men narke	P	Austin W. Bittle 19a. Informant's Name/Relationship (Type, Print) 19b. N	Anna V Mailing Address (Street and Number or Rural	Viegert	or Tours State Tie Co	odo)
a S	d 2 sh th and t7 is n traun				Carlisle,		100/
ē,	Heal Heal tam	1	20a. Method of Disposition 20b. Place of Disposition	Disposition (Name of Crematory or other place)	ate 20c. L	ocation - City or Town	, State
E O	Pages nent of ant: If i		11 Burial 2 MiCremation 3.1 Hemoval from State 1	Crematory, Inc. 6/14	/05 B	altimore,	MD
Baltimore,	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee Edward A. Gregorchik	22. Name and Address of Facility Cremation Society o 299 Frederick Road	f MD, Inc	• MD 21228	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause an each line.	t enter the mode of dying, such as cardiac or	respiratory arrest,	Ar	pproximate terval Between
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		ner	Sequentially list conditions, if any, Jacob to for as a consequence of cause. Enter Underlying Cause (Disease or injury				-
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.O. Box 6	law requires that the death certific as been signed by the attending [2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Da	ay Year
<u>α</u>	uires that (signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		use contribute to the c	cause of death?
Vital Records,	The ate h page	Completed			24a. Was an autopsy performed 1 Yes 2 Y N	death?	letion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		-
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	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	nd due to the cause(s d at the time, date ar	s) and manner as state nd place, and due to th	nd. e cause(s)
·	To th To th compl	Me	29b. Signature and title of certifier	MD 29c. License number		ate signed (Month, Day	
,	0		30. Name and address of person who completed cause of death (Item 23a) (TMADHU CHAUDHRY, 656.1)	ype, Print)		ine 13, 2	ORE
ſ	U			1. CHYTELES STRA	MO	21204	
	Sta Regist		JUN 1 4 2005 32. Digistrar's Signature	Speeds			

				State of Maryland / Department of Health and M 1- State Registrar Certificate of Death		giene Reg. No.	05	19730
		Physici		1. Decedent's Name (First, Middle, Last) Paul A. Baytop	2. Date of De Month	Day	2005	3. Time of Death 0506 A M
		/Medic Examin		4a. Facility Name (If not institution, give street and number) Since Hospital of Baltimore Ci	ty	4c. Cou	unty of Death	
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Yrs. 1 Months Days Hours Min. 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Nov 16	ay, Ye <i>ar)</i>	Cour	lace (State or Foreign try) yland
Q.		th the Maryland or 28e-f show a natified at	Irector	10a. State 10b. County 10c. City, Town or Location Baltimore 10e. Street and Number 10f. Zip Code		10g. Citizen	of What Cour	0d. Inside City Limits 1
ul Baytop	-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel; or items 23e or 28e-f show eumatic event, the Marical Examinar must be mailtied at	ed by Funeral Director	2527 Dennison Street 11. Marital Status 1 Never Married 1 Never Married 1 Never Married 2 Never Married 3 Never Married 4 Never Married 1 Neve		5pe	USA Race - Americ Black, White, ecify: bla of Business/in-	etc. .ck
Ta Ta	121215-0036	ted within 72 lygiene. her then "ne it, the Madit	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) Clerk (Give kind of work done during most of working into the clerk) Calerk				rity adm
x as	Maryland	d 2 should be filed th and Mental Hyg ?7 is marked othe treumatic event,	To Be		chel Vi	ctor		Code)
pt known	Baltimore, Ma	Pages 1 and ment of Health ent: if item 27 ury or other tr		Geneva B. Baytop/spouse 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		ore, M		16
		permit. Departe important injury inju		21. Specifier of Funeral Service Licensee Round of State Anatomy Board Baltimore, MD 2120 23a. Rart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or hear/failure. List only one cause on each line.	1		imore S	Approximate Interval Between Onset and Death
	8760,	/Medical Examiner whysicien and the pririal-transit	dical Examiner	resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to if as x consequence of): Due to if as x consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				-
	P.O. Box 6	The law requires that the death certific the has been signed by the attending propage 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d.	. Date of delive Month	ery Day Year
		w requires that t been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use		ne cause of death? ably 4 □Unknown
	al Reco	sicien: The law re certificate has be irector, page 2 sho	Completed		24a. Was auto perfi 1 Yes			psy findings available mpletion of cause of
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•		To the He within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier Pulled Pull of Certifier MD P50693 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDEN G. Provices 2461 W. Rulviculum Am. Ball 31. Date filed (Month, Day, Year) 32. Registra' Leignature 33. Registra' Leignature 34. Registra' Leignature 35. Registra' Leignature 36. Registra' Leignature 37. Registra' Leignature 38. Registra' Leignature 39. Registra' Leignature 30. Registra' Leignature 31. Date filed (Month, Day, Year)	S at the time	29d. Date si	igned (Month,	Day, Year)
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUSEN G. PEUPLES 246 W. Belvedure Au., Bal 31. Date filed (Month, Day, Year) 32. Registrative ignatures.	por	e, me	2121	5
		Sta Regist	ate rar	JUN 1 4 2005				

State of Maryland / Department of Health and Mental Hygier 🔒 🕦 🕤 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Blumberg 4.50 PM Sharon 2005 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death COLUMBIA 4c. County of Deeth Examiner Howard County General HOUPITAL Howard House 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MAY 4, 1952 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 200 F 216-52-6597 53 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4119 CENTURY TOWNE ROAD 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 Never Married 2 Married 1 Yes 2 No by Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MASTER COSMETOLOGIST COSMETOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **BLUMBERG ISADORE** BEATRICE **KESELONKO** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st nent of Health an ent: If item 27 is 1 ROBYN KATZ / SISTER 4119 CENTURY TOWNE ROAD - RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) ANSHE EMUNAH CHAIM) 06/12/2005 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Auneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pentl. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of help failure. List only ne cause on each line. Interval Between Onset and Death Immediat - ause (Final disease or condition resulting in death) Higatocellular Physician Carcinoma Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure, 2 No 3 Probably 4 □Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Caloria 24a. Was an autopsy performed? certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 0 29b. Signature and title of certifier D30573 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Mintra X 11065 Little Paturent Parkuny Columbia MD 21044. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature JUN 1 4 2005

Division of Vital Records, P.O. Box 68760,

	_ 1	For State Registrar	Otato or Mai	•	rtificate of		Mental Hygie	2000	13136
ciais		Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month	Day Year	3. Time of Death
sicia edica	al _	Samuel L. Cook						2005	12:15A
mine		4a. Facility Name (If not institution, ga	ive street and number)		4b. City, Town,	or Location of Deat	h	4c. County of Deat	h
		1804 Thornton Dr		Marine Total birds day		ashington		Prince Ge	orge's
al or		COALC.	Sex 7. Age 11X M 2 ☐ F	(In yrs. last birthday)	Months Day		(Month, Day, Ye		hplace (State or Foreigning) noke, VA
r	(m	579-46-2851 Usual Residence of Decedent		70 Yrs.			Oct 3, 1	934 Roa	noke, va
		10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limit
	to	MD Prince	George's	Ft. Wash	nington				¶∏Yes 2□N
,	Funeral Director	10e. Street and Number 1804 Thornton D:	rive		10f. Zip Code 2074		10g.	Citizen of What Co	ountry?
	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No-	14. Race - Ame	
	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Types 2 Types If Yes, Give	2-2-52	1 Yes 2 N		to Hican, etc.)	Black, Whit	
	þ	3 Widowed 4 Divorced	Year or Datest: O	5-31-86	1 Li Yes 2 Li N	o Specify:		Specify: W	hite
	Completed	15. Decedent's (Specify only highest g	Education	16a. Dece	edent's Usual Occ	upation e during most of wo	rkina 16	b. Kind of Business/	Industry
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	Sol	12		Resou	irce Mana			US Ar	my
	Be	17. Father's Name (First, Middle, Las					me (First, Middle, Ma.	_	
	၉	William Hamilto	n Cook			Iva Je	eanette Cl	ark ————	
l		19a. Informant's Name/Relationship	(Type, Print)				ural Route Number, C	-	
		Emogene Cook	(Wife)		Thornton		Ft. Washin		20744
1		20a. Method of Disposition F☐ Burial 2 ☐ Cremation 3	□Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	lace)	Date 20	c. Location - City or	Town, State
		'4 □Donation 5 □ Other (Spec		Albert's	Chapel (Cem. 6-8	8-05	Millstone	, WV
		21. Signature of Funeral Service Lic	97699	O 2	2. Name and Add Stump	ress of Facility	ome		
		234. Part . Enter the disease, or co sh. k, or heart failure. List on	Solder	V	P.O. B	ox 648 G	rantsville		47
	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enail Underlying Cause (Disease or injury	b	consequence of):	Cai	anow			
	cai	that initiated events resulting in death) Last	Due to (or as a d	consequence of):				and Date of the	1
Ī	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 4 Pregnant at t	Fetal death 3	□Ectopic pregnar □ Other (s <i>pecify)</i>			23d. Date of de Month	Day Year
	_		s contributing to death but	t not resulting in the	underlying cause	given in Part I.	23e. Did tobac 1 ☐ Yes		o the cause of death? robably 4 Unknow
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	ompieted by	Part II. Other significant conditions					24a. Was an autopsy performe	d2 prior to death?	utopsy findings availat completion of cause of
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And the second s	edical Certification; To Be Completed by	25. Was case referred to medical examiner? 1	28a. Place of Injun (Month, Day building, etc. Physician: To the best of aminer: On the basis of and manner state	Year) 28b. Time Injury ry · At home, farm, s (Specify) f my knowledge, dealexamination and/or i	of 28c. In W M 1 treet, factory, office the occurred at the occurred at the overstigation, in m 29c. Lice	Other: 4 Nursing I	autopsy performe 1 Ves 25 ath (Check only one) Home 5 Aesidence 28d. Describe how 28f. Location (Street City or Town, surred at the time, date	prior to death? 1 No 1 Yes to 6 Other (Speinjury occurred et and Number or Ristate) se(s) and manner as and place, and death	completion of cause of a large of the cause

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death	33
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year One One One One Year One Year One One One Note Year One One Note Year One One Year One One One Note Year One One Note Year One One Note Year One One Not	- 4
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5+ 120beth Nimsing (enter Saltimore) 4c. County of Death	//
	Funeral Director		5. Social Security Number 215-14-5462 6. Sex 1 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 30, 1922 9. Birthplace (State or F. Country) May 30, 1922 9. Birthplace (State or F. Country) May 30, 1922 Maryland	oreign
	Maryland f show	ō	Usual Residence of Decedent 10a. State	
	or 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	s 23a	rai [428 Gun Road 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-	
336	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event. I've Medical Examinational temodified at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Amed Forces? 16. Yes, Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes 2 ☑ No Specify: White	
2-0	72 hou	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry	
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Maryland	should be filed within and Mental Hygiene. marked other than metic event, the M	To Be (17. Father's Name (First, Middle, Last) Walter P. Carrion Bernardetta Link	
lary	ls a	-	19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	1 an Heal em 2	10	Gloria Smith Watson Carrion 428 Gun Road Baltimore, Maryland 21228 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State	
altimore,	B = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Cemetery, crematory or other place) St. Louis Church Cem. 6-16-2005 Clarksville, Maryla:	nd
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, MD 21228	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Oronary Arthury Disease (State Cause) Veav	
	/Medical Examiner		resulting in death) Due to (or as a consequence of): The first control of the c	1
1 /	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,
×,00	be executed sician and burial-transit	ıl Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
68760,	ificate t g physic as the b	edica	d	
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ar
	quires that n signed b uld be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Junk	•
of Vital Records,	The law requires: ate has been singage 2 should I	Completed	Chromic Africal fibrilation 24a. Was an autopsy findings aver performed? performed? death? 1 yes 2 pro 1 yes 2 pro 1 yes 2 pro 1 yes 2 pro 1 pro 2 pro 2 pro 2 pro 2 pro 2 pro 2 pro 3 pro 3 pro 2 pro 3 p	ariable se of
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within To the comple	Me	29b. Signature and title of certifier / 29c. License number 29d. Date signed (Month, Day, Year)	
•	σ .		MD D55391 June 13, 200	3
	/0		30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Ming Vi 3320 Blenson Avenue, Baltimore Maryland 212	27
	Sta Registr		31. Date filed (Nonth, Day, Year) 32 Negistrar's Signature JUN 1 4 2005	

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day Mary. Year COVER **Physician** 5:10 P.M 2005 cunse 10x /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll County Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 📆 🛣 Months 217-09-2147 96 May 22, Maryland Director 1909 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Itams 23a or 28a-f shov Examinar must be notified at Maryland Carroll Mt. Airy 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Huff Court 21771 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 ☐ No Specify: White þ 3X XWidowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Unknown Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe sny injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph A. O'Brien Dora Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Cover Son 126 Somerset Road, Stevensville, MD 21666 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Hill Cemetery 6/13/05 Owings Mills, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland

23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

A shock or heart failure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) MYOCARDIAL INFARCTION ONE **Physician** dery /Medical Due to (or as a consequence of) **Examiner** PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SENIL Demantiq 2 12 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed Osteo authorities 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 No 1 Yes 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25 No ၉ 1 Inpatient 2 KER/Outpatient 3 □ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Naturaf 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of celtifier D. 36469 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AI R. VELLANK. 8550 COLUMBIA (CC Parkway, \$308) COLLUMBIA. MD 21045. 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ľ	For State Registrar	otato or mi	arytana /	Cer	tificate of			Reg. No	.UUU	19/35
			Decedent's Name (First, Middle, La	st)					2. Date of D		y Year	3. Time of Death
	Physicia /Medic		THOMAS K. CARN	ES, JR.					JUNE	11	, 2005°	10:20 PM
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death		40	. County of Death	
			MANOR CARE ROS								BALTIMOR	
	Funeral		5. Social Security Number 6. S	ex 7. Ag Xa M 2□F	e (In yrs. last I		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D			olace (State or Foreign htry) INOIS
100	Director		140-14-7000		80	Yrs.			7/19/	1924	المالك ا	TNOTZ
0	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
28	danyl f sho	0	MD BALTIMO	RE	WHI'	TE M	ARSH					1 □ Yes 2 □XNo
)	ith the Marylar or 28a-f show	rect	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cour	ntry?
1.	3a or	Funeral Director	5142 BRIGHTLEAF	COURT			21237	7		Ū	ISA	
7	ms 2	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Spe	ecify Yes or N	0-	14. Race - Americ	
00 0	after death w or Items 23a	FE	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 XYes 2 If Yes, Give	No		r ves, specify Cuba I⊡ Yes 2y⊡ No	an, Mexican, Puèrto Specify:	rican, etc.)		Black, White,	etc.
33	72 hours after death with the Maryland natural", or Items 23a or 28a-f show diest Exactinat be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	WWII		1 1e2 \$\frac{1}{2} \tag{1.40}	эрвспу.			Specify: WH.	ITE
SSN 148 21215-0036	72 hours "natural",	Completed	15. Decedent's E (Specify only highest gra	ducation ade com <i>pleted)</i>	16	(Give	lent's Usual Occup kind of work done	during most of worki	ng	16b. K	(ind of Business/In-	dustry
5 12	e filed within al Hygiene. I othar than ", vant, tre M.	ш	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retired UTER PLAN	•		BΛ	LTIMORE	CTTV
	filed v Hygie othar I	ပိ	17. Father's Name (First, Middle, Last	5 YEARS		COPIE (JIEN FUAN	18. Mother's Name	(First, Middle			<u> </u>
and	ould be f Mental I larked of	Be c	THOMAS K. CARNE					RUTH SE		,		
1924 Maryland	2 should be and Mental is marked c	To	19a. Informant's Name/Relationship (1:	9b. Mailin	g Address (Street	and Number or Rura	il Route Numi	ber, City	or Town, State, Zip	Code)
) Wa	I and 2 should be filed within 72 hours after death with the Maryla Realth and Mantal Hygiene. It Health and Mantal Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 shorthar traumatic event, Ite Madical Examinational be notified.		MARY E. CARNES/W			5142	BRIGHTLE	EAF COURT	BALTI	MORE	, MD 21	237
19/	of Health of Health itam 27 i		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	(ac)	Date	20c. L	ocation - City or To	own, State
- e	Pages nent of I int: If its		1 ABurial 2 Cremation 3 C 1 Donation 5 Other (Special		MOST	HALX	REDEEMER ERY	6/15	5/2005	BAL	TIMORE,	MD
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a a	P P E C C		1/			8.	521 LOCH	RAVEN BLV	D. TO	WSON	, MD 21	286
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death. D	o not ent	er the mode of dyin	ng, such as cardiac o	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	HUDE	VAGNON	ic.	Peso, ma	Voy Fai	lure	_		Onset and Death
2	/Medical		resulting in death)	Due lo (or as	a consequence	e of):	2 . 0.					2
Son	Examiner		Sequentially list conditions.	b. Enc	1 SARG	10	COFD					Lyvs.
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5 68760	physis the	Medicai	•	d								
0 ×			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy						23d. Date of delive	ery
- B	The law requires that the death certe has been signed by the attendir	Physician/	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a]Ectopic pregnancy] Other <i>(specify)</i>	/			Month	Day Year
	t the c by the	hysi	9 Unknown	9□ Unknown								
() a	res thai		Part II. Other significant conditions	contributing to death b	out not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to th	ne cause of death?
ords	w require been sig should b	Completed by	CHE W	Demont	na -				1	Yes 2	□ No 3□ Prob	pably 4 Gunknown
nos Reco	aw re	piet							24a. Wa	s an opsy	24b. Were auto	psy findings available mpletion of cause of
	The I	Com							peri 1 ☐ Yes	formed?	death?	
Vital Vital	cian: Th ertificate ector, pag	Bec	25. Was case referred to medical examiner?					26. Place of Death	(Check only	one)		
-	hysician: this certific al director,	L P	1 Yes 2 INO	Hospital: 1 ☐ Inpati	ent 2 ER/	Outpatien		er: 4 Nursing Ho	me 5□Res	sidence	6 ☐Other (Specif	y)
, 0	- L		27. Manner of Ceath 1 Statural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28t ay Year)	o. Time of Injury	Wor		28d. Describe	how inju	ry occurred	
SS	Mtandi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No	000			
n &S,	I or Attan after dea Diractor	Certification:	4 Homicide determined	28e. Place of In building, e	jury - At home, tc. <i>(Specify)</i>	farm, str	eet, factory, office		City or To	(Street al own, State	nd Number or Rura e)	il Houte Number,
S. P. D.	urs urs aral	Ce	29a. Certifier 1 Certifying P	hysician: To the best	of my knowless	Ide death	occurred at the 45-	me date and place	and due to the	a cause/s	and manner as a	tated
2	Hos Fun ely	edicai		miner: On the basis of and manner st	of examination							
	To the within 2 To tha complet	Me	29b. Signature and fittle of certifier				29c. Licens	se number		29d. Da	ate signed (Month,	Day, Year)
	- > - 0		1 Th 1 40	1 - ul 12			MA	15702	1	1	113/04	5
	1 1		30 Name and address of person who	completed cause of	death (Item 23	a) (Type,	Print)	7	1	<u> </u>	1 1 1 2	7
3	1		Rita Mighu	r. 41.0.	910	6	minulel	pha K	d. 8	Ar I	200	
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1	R.P					
	Registr	ar	4 000	5	. 15 A	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						

Pamela Jean Cernik Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03990 1- State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. NJM 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 2005 1622 Pamela Jean Cernik June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1401 F Pulaski Highway Harford Edgewood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/27/1960 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 KF 44 Director 219-84-2944 MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 21040 615 Banyan Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2N No Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔊 No Specify: ^{Specify:}White δ 3 ☐ Widowed 4 ☐ Divorced If Yes, Give / Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Veterinary than College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) William A. Cernik Elizabeth Francis Brocklehurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Cernik/Father 3833 Memory Lane, Apt. C Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jun 13 Beltsville, Maryland Chesapeake Crematory Inc. 2005 21. Signatured Fundal Service Licensee W00986 22. Name and Address of Facility
Cremation and Funeral Alternatives Mu 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ethanol and Mixed Drug(Oxycodone and Quetiapine)Intoxication Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trans and Due to (or as a consequence of): of Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) JYes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown ieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Compi autopsy performed? 2 🗆 No 1 Yes 2 🗆 No es 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Scene Yes 2□No within 24 hours after death. To the Filneral Director: After this 27. Manner of Death 28a. Date of Injury **Found** Day Year) 28b. Time of 28d. Describe how injury occurred **Subject ingested alcohol and** Certification; or Attending Found 1 Natural 5 Pending 1 🗌 Yes 2 **X** No 2 Accident 3 Suicide investigation 4:19 6-10-05 drugs 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Bural Route Number, City or Town, State) 1401-F Pulaski Hwy. 4 🗌 Homicide Found in auto Edgewood, Md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified St. OCME June, 11, 2005 (Rem 23a) (Type, Print) Penn Street Baltimore, Maryland 21201 Name and address of person who completed cause of de 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 1 4

2005

ORIGINAL

			1 - For State Registrar	State of Ma	aryland		artmen rtificat					giene Reg. No.	005	197	137
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	a-f sh	tor	MD Howard		Sav	age .								1 □ Ye	s 2 No
	or 28	Dire	10e. Street and Number				10f. Zip					_	en of What C	ountry?	
	ns 238	eral	8532 Storch Woods	2. Was Decedent		13.1		0763	snanic Ori	gin? (Spe	cify Yes or No		S.A. 4. Race - Am	erican Indian	
39	ges 1 and 2 should be illed within 72 hours after death with the Maryland it of Health and Mentat Hygiene. If Itam 27 is marked other than "netural", or Items 23a or 28a-f show or other traumatic svant, the Maralcal Examinatic suarities and illed at an or other traumatic svant, the Maralcal Examinatic suarities at a standard in the motiliary at a standard in the motiliary at a standard in the motiliary at a standard in the motiliary at a standard in the motiliary at a standard in the stan	by Funeral Director	1 Never Married 2 Married 3 XXVidowed 4 Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	_		lf Yes, spec 1 ☐ Yes	cify Cubar	Specify:	i, Puerto	Rican, etc.)		Black, Whi		
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.O. Box 6	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 △ No	lc. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal d	death 3	Ectopic pr Other (sp					23	3d. Date of de Month	livery Day	Year
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	.1		Jon K. 1111 w	401	λ 10·			D305	73			June	7, 20	05	-
	12		30. Name and address of person who cor John Minford, M.D.	npleted cause of d 11065_ I				Park	wav	Colu	ımbia.	Marvl	and 2	1044	
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			1 - For State Registrar		f Marylar		artment rtificate		ealth and I Death		Reg. No.	05 19738
	Physici	an	1. Decedent's Name (First, Middle M			D 1				2. Date of De Month	Day	Year 3. Time of Death
	/Medic	al	Margie	Α.		Darb			Landing of Double	June		005 4:39 M
	Examin	er	4a. Facility Name (If not institution Washington Co	-			4b. City, T		Location of Death Serstown	1	4c. County of	
			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under 24 Hrs.	8. Date of Bir	th	nington 9. Birthplace (State or Foreign
	Funeral Director		453-18-8949	1□ M 2□F	85	Yrs.	Months	Days	Hours Min.	July 18	ay, Year)	9. Birthplace (State or Foreign Country) Cexas
	ъ		Usual Residence of Decedent								, , , , , , ,	
	irylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo						10d. Inside City Limits
	8a-1 s	cto	Maryland Frede	rick		R001	isboro					1 ☐ Yes 2 ☐ No
	i 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show close Exercises mast be collitied at	al Director	7222 Wheeler	Road			10f. Zip (217	713		10g. Citizen of W	•
	er dea Items	Funeral	11. Marital Status	Armed Fo		l.S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race Black	e - American Indian, k, White, etc.
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Baltimore,	Se to L		1 ☐ Burial 2 🛣 remation 4 ☐ Donation 5 ☐ Other (5		State Lee	cemetery, crei e Crema	natory or oth LCCV	her place) Jur	ne 9, 2005		Maryland
Ħ	permit. Pag Department Important: I any injury o		21. Sign sture of Funeral Service				2. Name and	Addres	s of Facility		eral Hom	
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	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):	A		0 4			1
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ox 6	eath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn						23d. Date	e of delivery
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	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No	Hospital	Inpatient 2	ER/Outpatier	nt 3 DOA	Othe	26. Place of Dea		dence 6 Othe	ar (Specify)
of			27. Manner of Death	28a. Date		28b. Time o		Bc. Injury Work			how injury occurre	
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Division	l or Attene after death Director: I in by the	Certification:	3 🗍 Suicide 6 🗍 Could 4 🗍 Homicide determ	nined 288. Place	of Injury - At h ing, etc. (Speci	iome, farm, st	reet, factory,	office		28f. Location (City or To		er or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier X Certifyi	ng Physician: To the	a bast of my ko	owledne dest	h occurred a	it the tim	e date and place	and due to the	cause(s) and man	oner as stated
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		Me	29b. Signature and the of certifie				29c.	License	number		29d. Date signed	(Month, Day, Year)
	9			1			D	44	996		June '	0,2005
	10		30. Name and address of person	Who completed cau	se of death (Ite	m 23a) (Tipe,	ppans	Ro	1 Boon	storo	MD 217	713
	Sta Registi		31. Date filed (Month, Day, Year JUN 1 4	005	legistrar's Sign	ature	W					

			For State Registrar		State	of Man	yland /			t of Hea		Mental Hy	ygiene	05	19739
-			1. Decedent's Nam	e (First, Middle	e, Last)			7-41-				2. Date of D Month		Year	3. Time of Death
	Physici /Medic		Doris			В.			Ea	aster		June	og Og	2005	3:20a.M
	Examin				n, give street and n	ımber)				Town, or Lo	cation of Dea	ath	4c. Co	unty of Death	
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	Funeral Director		5. Social Security N		6. Sex 1 □ M 💥 💢 F	7. Age ()	In yrs. last b 5	Yrs.	Months		Hours Min	S. B. Date of B (Month, D	6 20	9. Birtho Court	lace (State or Foreign htry) anama
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	yland		10a. State	10b. County	-		Oc. City, To					_		1	0d. Inside City Limits
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	ith th	Dire	10e. Street and Nu						10f. Zip		-			of What Cour	ntry?
	s 23a	Funeral Director	3928 0	akford	Ave	and and Core		12 1	Va a Danas	2121		(Coords Vec or N		S · A ·	on Indian
	ter de Item	-un-	11. Marital Status 1 ☐ Never Man	ried 2107 Mar	Armed F	orces?	ar in U.S.	13. ¥	Yes, spec	cify Cuban,	Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	10-	Black, White,	
036	urs af	by	3 Widowed		If Yes G	ive		1	☐ Yes	2[X No 3	Specify:		Spi	ecify: B.	lack
Õ	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-f show the Marical Examiner must be motified at	Completed	/500	15. Deceden	it's Education st grade completed	1	16	a. Deced	ent's Usua	al Occupation	n no most of w	orkina	16b. Kind o	of Business/Inc	dustry
215	ithin 7	nple	Elementary/Sec	ondary (0-12)	College	(1-4or 5+)					ng most of w	onning .		Home	
2	led w lygier her th	CO	12th g:		na (nat)			г	10 u S	ewife		omo /Cirot Middl			
and	ntal Hed ot	Be	17. Father's Name							10	. MOUNER'S IN	ame (First, Middl	e, Maideri Sui	name) Unl	known
Maryland 21215-0036	thould Me Id	2	David 19a. Informant's N				19	9b. Mailin	a Address	(Street and	Number or I	Rural Route Num	ber. City or To	wn. State. Zip	Code)
	ulth an 27 is rtrau		4		er-Husb	and			•	,		, Balti			21215
ا ق	s 1 ar f Hea item othe		20a. Method of Dis	position			20b. Place	of Dispos	sition (Nar			Date		on - City or To	wn, State
, ર્ર દે	Page nent o nnt: If iry or		1 □ Surial 2 1 □ Donation	☐ Cremation 5 ☐ Other (S	3 □Removal from Specify)	State	Garr	. *			6/:	17/05	Owin	gs Mi	lls, Md
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important: If them 27 is marked other then "naturel", or Items 23a or 28e-1 show any injury or other traumatic event. The Machall Examiner must be natified at once.		21. Signature of F	yneral Service	Licensee	6				F/H		e, Balt	imore	, Md	21215
(A)	100		23a. Part1. Enter	the disease, or	r complications that only one cause on	caused the	e death. Do								Approximate Interval Between
	Physician /Medical		Immediate Cause disease or conditi- resulting in death)	(Final	a	14/	/ //e	1	cci	1/11	1 21	14 50	2051	15	Opset and Death
	Examiner				Due to	(or are a c	dence	θ 0η.		(5-0 MM)		/			C
10		ner	if any, leading to it cause. Enter Und Cause (Disease or that initiated event	unditions, mmediate eriving	Due to	(or as a c	consequence	e of):							
200	ocuted nd transi	Examiner	Cause (Disease of that initiated event resulting in death)	r injury s	c										
6.09	ate be executed hysician and the burial-transit	E	1930iting in death)	Last	Due to	o (or as a c	consequence	e of):							
9 2	physic	dical			d		· · · · · · · · · · · · · · · · · · ·	· <u>-</u>							
) Box 68	*= CD ett	Physician/Med	IF FEMALE: 23b. Was deceder		23c. If yes, o	utcome of	pregnancy						23d.	Date of delive	erv
B	death atter	iciar	in the past 12	menths?	4□Preg	nant at tim	∏Fetal deat ne of death		Ectopic pi Other (sp						Day Year
ွ ဝ	at the d by the tached	hys	9 Unknow		9□ Unk	nown									
S. P	es that the de igned by the be detached	by P	Part II. Other sign	ificant conditi	ons contributing to	death but r	not resulting	in the ur	nderlying o	ause given	in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?
	w require been si			VH								1]Yes 2□N	o 37 Prob	ably 4 Wiknown
Record	e faw r has be ge 2 sh	Completed			/							24a. Wa	opsy	prior to, cor	psy findings available in pletion of cause of
171 E	The cate h	Con											formed? 2 No	death! 1 D Yes	2□ No
Vital Cr	ti cien : Th certificate rector, pag	Be	25. Was case refe examiner?	rred to medica	Hospital:							eath <i>(Check only</i>			the was
i S 1	Physicien: r this certificantal director,	2	1 ☐ Yes 2 2 27. Mann or of Dea	No th	1 _	Inpatient of Injury	2 ER/0	Outpatien . Time of				Home 5 Res	sidence 6 🗷 how injury oc		MISTICE.
on on	ding P. h. After funera	tlon	1 Natural 2 Accident	5 🗌 Pendir investi	13	of Injury nth, Day Y	'ear)	Injury	М	28c. Injury at Work? 1 ☐ Ye	3 2 □ No				/
Doe	Attending r death. sctor: After oy the fune	fica	3 Suicide	6 ☐ Could	not be 28e. Plac	e of Injury	- At home,	farm, stre	et, factor	y, office				umber or Rura	I Route Number,
	s afte	Certification:	4 🗌 Homicide		buil	ding, etc. (Ѕресіту)					City of Te	own, State)		
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)		ng Physicien: To the Examiner: On the and ma		camination a								
	To the within To the To the To the Comp.	ž	29b. Signature and	d title of certifie	Minus	2 1	M		290	Dicense n	umber 2012		29d. Date si	gned (Month,	Olay, Year)
_	X		30. Name and add	Iress of person	who completed car	use of deat	th (Item 22a	(Type, I	Print)	nd!	RN	034	him	12	2/0
	Sta Regist		31. Date filed (Mo.	nth, Day, Year,	1 4 2005	Registrar's	Signature	× 1	port		W	- F G'//	914		V
										14					

			1 - For State Registrar		State of	Maryland /		artmen rtificat				ental Hy	ygier Reg. N	. 00	5	197	40
	Physic		1. Decedent's Name Emi		ast) ters Er	icson					Į.	2. Date of D Month une	eath 09	2005	Year	3. Time o	of Death) A M
	/Medi Examir		4a. Facility Name (/		ve street and num				Town, or	Location of	of Death	-		lc. County	of Death		
	Funeral Director		5. Social Security N 213-26-8	umber 6.		7. Age (In yrs. last i	oirthday) Yrs.		1 Year Days	If Under Hours	24 Hrs. 8 Min. Aug	B. Date of B (Month, D ust 2	irth ay, Yea			lace (State try) Land	or Foreign
	D		Usual Residence of	Decedent 10b. County		10c. City, To	wn or Le	ocation								0d. Inside (
	e-f sho	ctor	MD	Baltim	ore	Pikes	vil	le								1 ☐ Yes	s 2 No
	with the	i Dire	10e. Street and Number 626 Mi	_{mber} litary A	venue			10f. Zip	Code 21208	3			_	citizen of W			merica
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic evant. The Medical Expranant rust be muitted at once.	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ied 2√ Married 4 □ Divorced	12. Was Deced Armed For 1 Tes If Yes, Give Year or Da	² ₹ ^{No}		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spec n, Puerto Ri	ify Yes or N can, etc.)		14. Race Black		an Indian, etc.	
21215-0036	n 72 ho "natur	Completed		15. Decedent's E lify only highest g		16	(Give	dent's Usua kind of wo DO NOT us	rk done d	turina mosi	t of working	7	16b.	Kind of Bus	siness/Ind	dustry	
212	d withli giene. er than	Somp	Elementary/Seco	ndary (0-12)	College (1-	4or 5+)		ome Ma		,				Own	Home		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "raumatic evant, the Mark	To Be (17. Father's Name Unknown	(First, Middle, Las	t)					18. Mothe		First, Middle Unknov		an Sumame	9)		
lary	2 shoul and Me is mark	F	19a. Informant's N	,		15	9b. Maili	ng Address	(Street a	ind Numbe	ar or Rural i	Route Numi	ber, City	or Town, S	State, Zip	Code)	
	Health Health tem 27		Mr. He:	nry E. E	ricson	20b. Place	26 N of Dispo	Milita	ary A	lvenu	e, Pi	kesvi		Mary Location - 0			8
Baltimore,	Pages nent of ant: If it		th⊠Burial 2		□Removat from S	como	Ric	matory`or o lge Ce	ther place emete	ry (06/10	/05	Pik	esvil.	le,	Mary1	
Balti	permit. Departn Imports any inju		21. Signature of Fu			40033						ng Pye Randal					ors,In 21133
	***		23a. Part1. Enter t	ne disease, or cor		used the death. D		-						0		Approxima Interval Be	ate etween
	Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final	a. De	or as a consequence	of):	ulu	W	di	le T	to	201	D	-	Onset and	Death
8760,	ate be executed shysicien and the burial-transit	cal Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	•	c.	or as a consequence											
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 Live bi	ome of pregnancy th 2 Fetal dea int at time of death wn		Ectopic pr						23d. Date Mon		ry Day	Year
Vital Records, P	w requires that been signed b should be deta	by	Part II. Other signif	icant conditions	contributing to de	ath but not resulting	in the u	nderlying c	ause give	on in Part I.		23e, Did		use contri	bute to th		death?]Unknown
Rec	he taw e has b age 2 sl	Completed		-									ormed?	pr de	rior to cor eath?	osy findings npletion of	s available cause of
/ital	ysicien: The is certificate h director, page	Be C	25. Was case refer examiner?	red to medical						26. Place	of Death /	1□ Yes Check only		10 11	Yes	200 No	
of	문 두 등	. To	1 Tes 222	•	Hospital: 1 In In 28a. Date o	patient 2□ER/0	Outpatier . Time o		8c. Injury Work	4 LI NU		d. Describe				1)	_
sion	Attanding For death. sctor: After by the funera	atlor	Natural 2 Accident	5 Pending investigate	on	, Day Year)	Injury	М		:? ∕es 2 🗆 t	No						
Division	al or Att after de I Direct d in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	4 286. Place	of Injury - At home, g, etc. (Specify)	farm, sti	reet, factory	, office		28	f. Location City or To			r or Rura	l Route Nui	mber,
	To the Hospital or Attand within 24 hours after death To the Funarel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	Certifying P	hysician: To the iminer: On the ba	pest of my knowled sis of examination a er stated.	ge, deat and/or in	h occurred vestigation,	at the time, in my op	e, date and inion, deat	d place, an th occurred	d due to the at the time	cause(s) and man	ner as st	ated. the cause	(s)
)	To the vithin Comp	Me	29b. Signature and	title of certifier	m Ru	ed 1	MI	290	License	number 48	88		29d. D	Pate signed	(Month,	oay, Year)	5
ل			Allen	ess of person who	red m	of death (Item 23a) (Туре, <i>О</i>	Print) 183	86	ree	enc	133	2 K	Q. 1	Ba	Hin	oce
	Sta Regist		31. Date filed (Mon	th, Day, Year)	32. Re	gistrar's Signature	K	Snea	les.						N	10 z	1208
DH	MH 17 Rev 1/2	001		- JUN J	2 2005	OR	IGIN	AL.									

			1 - For State Registrer	State of Maryland		ment of Heali			71115	19741
			Hegistrer Decedent's Name (First, Middle, Last	it)	Oertii	icate of Dea	1111	2. Date of Death	J. No. 9 0 0	3. Time of Death
	Physici /Medic		CASEY			FLO	40	JUNE TUNE	Day Year	920 PM
	Examin		4a. Facility Name (If not institution, give	street and number)	, , 4	b. City, Town, or Local	tion of Death		4c. County of Dea	ath
			THE JOHNS HO	Kins Hospita	7/	Onder 1 Year If Ur	nder 24 Hrs.	0. Date of Dist	0.00	
П	Funeral Director		5. Social Security Number 6. S	7. Agé (In yrs. In		Ionths Days Hor	urs Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bi	rthplace (State or Foreign ountry)
	ס		Usual Residence of Decedent	70				10 00-	(00 W	Virginia
	arylan show	<u>.</u>	10a. State 10b. County	10c. City	, Town or Locat	ion				10d. Inside City Limits
	28a-1	ecto	VH Shenar	dooh	Cali	Durg			0	1 □ Yes 2 No
	with t		10e. Street and Number	7		10f. Zip Code	1282	1	g. Citizen of What C	L ountry?
	ms 23	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Wa	s Decedent of Hispaniess, specify Cuban, Me:	c Origin? (Spe	cify Yes or No-	14. Race - Am	
9	or its	F	1 Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No		1		Rican, etc.)	Black, Whi	te, etc.
003	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			ecify:		Specify:	Shite.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or Itams 23a or 28s-f show ant, the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	de completed)	(Give kin	t's Usual Occupation of work done during NOT use retired)	most of working	ng 16	b. Kind of Business	/Industry
212	ywith jene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Cocoo	rate Vt)	6	ov + Con-	tract Firm
פ	e filec al Hyg othe vant.	Bec	17. Father's Name (First, Middle, Last)		COPS	18. N	Nother's Name	(First, Middle, Ma		
ylaı	Mente Mente arkad	To	John F.	Floyd.			Heler	H.	Faw	
Maryland	2 sho		19a. Informant's Name/Relationship (7	уре, Print)	19b. Mailing A	Address (Street and Nu	01	. /	City or Town, State,	Zip Code)
	Health Health tam 27 i		20a. Method of Disposition	20b. Pl	ace of Disposition	OSCTUT.	cding		c. Location - City or	Town State
nor	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, cremate	ory or other place)			9.91	II ME
Baltimore,	표된 문문 등	Ì	21. Signature of Funeral Service Licen			CHAPEL- ame and Address of F 2325	acility av		ocest th	021092
m	Depa impo any i		Eximple le 4	· Soundtren	PFA	CEFILAC	TO RUA	TIVESFUE	FRACECK	CEIMATION CTR
H			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	. Do not enter t					Approximate Interval Between
E	Pnysician :		Immediate Cause (Final disease or condition	S. PSis						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequ	ence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	an and rial-tra	Exa	resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	The law requires that the death certificate be executed at the bas been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Medical	(d						
Box 6	that the death certifice ed by the attending ph detached for use as t	/Mec	IF FEMALE:	23c. If yes, outcome of pregnar	201					
Bo	atten	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ec	topic pregnancy her (specify)			23d. Date of de Month	livery Day Year
P.O.	the d by the ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown		(4,500.1)/				
	w requires that been signed b should be deta	by P	Part II. Other significant conditions co			rlying cause given in P	Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	equire sen sig ould b	ted	NON-SPECIFIC IN			· · · · · · · · · · · · · · · · · · ·		1 🗆 Yes	2 No 3 □ P	robably 4 Unknown
ecc	law r nas be	Completed	Now-is (hemic Secondary pulma	Cardiomyopati	4			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
E H	cate h			very hypertens	ion			performe	d? death? No 1 ☐ Yes	2 □ No
<u>=====================================</u>	Attending Physician: or death. ector: After this certifice by the funeral director, g	Be	25. Was case referred to medical examiner?	Hospital:		7		(Check only one)		
of	Physic this seal di	7: To	27. Manner of Death	1 Inpatient 2 E	28b. Time of	28c. Injury at Work?		8d. Describe how	e 6 Other (Spe	city)
ion	ath. r: Afte	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 Yes	2 🗆 No			
Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		factory, office	21	8f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	oital or urs afte irat Dir									
	Hosi 24 ho Fung stely f	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	rsicien: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death oc on and/or invest	curred at the time, date igation, in my opinion,	e and place, as death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funarat Director: After this certificate has completely filled in by the funeral director, page 2	Me	79b. Signature and title of certifier	and the state of t		29c. License numb	ber	29d	Date signed (Mont	h, Day, Year)
-		2/	Brad & Fall	J, ms		RES-	000	Ju	ne 08 ; ?	1005
1	01		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type, Prin					
7			Brad Sutten John 31. Date filed (Month, Day, Year)	s Hopkins Hospital	600 No	th wilt? Sire	ret B	alt muse,	Vri 212	87
	Sta Registra		JUN 1 4 200	2. Registrar's Signatu	March	-				

			For State Registrar	State of	f Marylan	d / Depa		t of H	ealth a		lental Hy		005	197	42
	Physicia		Decedent's Name (First, Middle,	Last)					-		2. Date of De		Year	3. Time of	
	/Medic Examin	al	Rita Marie 4a. Facility Name (If not institution,	give street and nu	mber)				Location of		JUNE	4c. C	ounty of Death	1811	FM
	Funeral		5T. AGNES HEAL' 5. Social Security Number	H CARE	7. Age (In yrs.	last birthday)	If Under	1 Year	1 Under	24 Hrs.	8. Date of Birt	h	9. Births	olace (State or	r Foreign
	Funeral Director		213-18-1693 Usual Residence of Decedent	1 □ M 2017 F	85	Yrs.	Months	Days	Hours	Min.	March 2	y, Yea <i>r)</i>		yland	
	anyland show	_	10a. State 10b. County		10c. Cit	y, Town or Lo							1	0d. Inside Cit	-
	the M	recto	Maryland Balti 10e. Street and Number	more		Caton	svill 10f.Zip					10g. Citize	en of What Cour		
	th with	al D	2120 Cedar Cir	cle Driv	e			212	28			1	U.S.A.		
980	permit. Pages 1 and 2 should be filed within 72 hours attar death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23e or 28e-f show amy injury or other traumatic evant, it is Modical Eracinal month to notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 A Marrie 3 Widowed 4 Divorced	Armed Fo	2⊠No ve		Was Deced If Yes, spec				ecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.	
Maryland 21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during mos	t of work.	ing	16b. Kind	of Business/In	dustry	
27	iled wi Hygien Ihar th		12 17. Father's Name (First, Middle, L	ast)		Hom	emake	r	18. Mothe	er's Name	e (First, Middle,	Maiden S	Own Hor	ne	
land	ild be f fental P rkad of	То Ве	Dominic Moran								y King				
lary	2 shou and M Is mai		19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Numbe	er, City or T	Town, State, Zip	Code)	
ē,	1 and Health am 27		John Paul Fromm 20a. Method of Disposition	ı (Husba	20b. F	Place of Dispo	Ceda:	ne of			re Cato		Lle, MD ation - City or To		
Ö	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	emetery, cre. w Cath	,		· 1	6-15	-2005	Balti	imore, 1	Marylar	nd
Baltimore,	permit. Departir Importa any inju		21. Signature of Funeral Service L	Daly	suster		2. Name an itzke 630 E	d Addres Fun dmon	s of Facilit eral dson	Home Ave.	of Cat	onsvi ville	ille, Ii	nc 1228	
6	*		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause on	caused the deat	h. Do not en	ter the mod	e of dyin	g, such as	cardiac (or respiratory a	rest,		Approximate Interval Betw Onset and D	veen Seath
	/Medical		disease or condition resulting in death)	a NEC	Or as a consequence of RAT	(Uniquence of):	DITT	Co	011110					3 DAG	15
B	Examiner	_	Sequentially list conditions,	b. AS	Or as a conseq	ION	PNE	UM	ONI	A					
7	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	(0, 43 4 00),300	(46)									
, '09/	ite be axecuted ysician and ne burial-transit	cal Exa	resulting in death) Last		(or as a conseq	uence of);									
99	5 × 5			d											
P.O. Box	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	itcome of pregna birth 2 Peta nant at time of c nown	al death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					23	d. Date of delive Month	-	'ear
	uires that the dea n signed by the a ld be detached f	by Pt	Part II. Other significant conditio								23e. Did t		e contribute to the		
ord	w require been si should b		HYPERTENSI	ON, DE	MENI	171 14	4POJ	1+11	ROID	15,21	1 🗆 `		No 3 ☐ Prob		
of Vital Records,		Completed	CEREBRALL	MSCULF	DE DCC	DEI	VI.				24a. Was autor perfo 1 \(\text{Yes}	rmed?	24b. Were auto prior to co- death? 1 \(\subseteq Yes	psy findings a mpletion of ca	
Vita	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Impatient 2□	EP/Outpatio	n) 2 🗆 DC	Oth			h <i>(Check only c</i> me 5 ☐ Resi		Other (Specif	w1	
		H-	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time of		8c. Injun Wor	y at k?		28d. Describe I			7)	
Division		ertification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r	ation			М	1 🗆	Yes 2□	No	29f Location (Stroot and	Number or Rura	J Pouto Numb	hor
DİX	al or Attanos after death	Sertif	4 Homicide determi	ned 286 Plac build	e of Injury - At h fing, etc. (Speci	fy)	reet, tactor	у, описе			City or To		IVUITION OF PUTA	I Hoble Name	767,
	To tha Hospital or A within 24 hours after To tha Funaral Directorpletely filled in by	edical C		g Physician: To th Examiner: On the I and mar											
)	To the within To the comp	M	29b. Signature and title of certifier	= M.D					60 (4			signed (Month, NE, 12,		
	N		30. Name and address of person of ABDUL SAIDI					T.1	10RE	A A	0 212	20			
450	Sta	ite	31. Date filed (Month, Day, Year)	900 S 2005	egistrar's Sign	ature	land .	1	IUNE	101	1) -10				
	Regist	rar	JUN 1 4	2005	alue 1	D. 19	984(1)								

				partment of Health and Mertificate of Death		ene 005	19743
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Robert Marvin Files		6	11 2005	
	Examin	er	4a. Facility Name (If not institution, give street and number) 520 White Oak Drive	4b. City, Town, or Location of Death Severna Park		4c. County of Deal	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth		thplace (State or Foreign
	Funeral Director		233-34-3542 12 M 2□F 83 Yrs.	Months Days Hours Min.	(Month, Oay, 1 11/24/19	rear) Co	WV
	72		Usual Residence of Decedent				
	aryłar show	Ĕ	10a. State 10b. County 10c. City, Town or MD Anne Arundel Severna				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Pe M	ectc	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	
	with a or i	Funeral Director	520 White Oak Drive	21146	100	USA	*
	ns 23	era	11 Marital Status 12 Was Decedent Ever in U.S. 13	I. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show entry injury or other traumatic event, the Madical Exacting must be notified at ODGe.	by Fun	Armed Forces? 1 Never Married 2 Married 1 Ves 2 No If Yes, Give 7 Vear or Dates:	If Yes, specify Cuban, Mexican, Puerio I 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, Whit	e, etc. White
Ö	72 hor	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation we kind of work done during most of working	16	6b. Kind of Business	Industry
2	thin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Automotive	2
2	fled w tygier her th	Be Completed	12 17. Father's Name (First, Middle, Last)	Mechanic 18. Mother's Name	(First Middle Ma	aidan Sumama)	
Maryland 21215-0036	d be f	To Be	Marvin Horton Files Sr.			le DeLance	5 À
37	shoul nd Me mark	Ě		iling Address (Street and Number or Rura	l Route Number, (City or Town, State, 2	Zip Code)
Ž	and 2 alth a n 27 Is		Mrs. Carolyn F. Hill / sister 520	White Oak Drive, Se	everna Pa	ark, MD 21	146
altimore,	of He of He fitem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, completely,	position (Name of ematory or other place)	000=	Oc. Location - City or	
Ē	ment ment lent: I		`4 □Donation 5 □Other (Specify) Glen Hav	en Cemetery	2003	Glen Burni	.e, MD
Ball	permit. Depart Import eny in		21. Signature of Funeral Service Licensee William Downly M0/4/5 1	22. Name and Address of Facility Sir Second Ave SW Gler	ngleton E n Burnie	Funeral Ho MD 21061	me P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
H	Pnysician		Immediate Cause (Final disease or condition resulting in death)	ncer			18 months
	/Medical Examiner		Due to (or as a consequence of):				
	mē.	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	d d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Deceas of Myll) that initiated events c.				
o O	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dicai	d				
9	eath certific attending plifor use as t	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			024 Date of dat	
Box	atten atten I for u	Physician/Me	in the past 12 months?	☐ Ectopic pregnancy		23d. Date of del Month	Day Year
O.	that the de led by the a detached f	hysi	1 Yes 2 No 9 Unknown 9 Unknown	,,			
<u>s</u>	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as:	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been sig should b	ted	Emphysema		1 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Record	e law r has be je 2 sh	Completed			24a. Was an autopsy	prior to	topsy findings available completion of cause of
E		Con			performe	nd? death? No 1 ☐ Yes	2 No
Vita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death Other: 4 Nursing Hor	25,545		
ot	Phys r this aral di	To :	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	ne Residen 28d. Describe how	ce 6 Other (Specially occurred)	cify)
lon	nding I th. :: After e funer	atior	1 Datural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	or Attendater death Director: in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	itel or A	Cer				<u></u>	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, de 2 Madical Examinar: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, date	e and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Monte	h, Day, Year)
•	Ti		Januar Jonnan MD	VOV 430 11	4	113/20	05
	10		30. Name and address of person who completed cause of death (Item 23a) (Typ Jonathan Fonney Mo 1406B	S. (rais 304 6/e	4 BULL	1e 40 2	1061
	Sta Registr		31. Date filed (Month, Day, Year)	29c. License number DOD 238 11 e. Print) Se (rain 324 6/e			
	. riegisti	-GII					

		1	For State Registrar	State	of Maryl	and / De <i>C</i>	partment of H ertificate of L	lealth and N Death		jiene 0	15	19744
			Decedent's Name (First, Middle	Last)					2. Date of Dea		Year	3. Time of Death
Physi /Me	ician dical		Charles			arrall			June 9		15 15	9:58AM M
Exan			a. Facility Name (If not institution Doctors Hospi		number)		Lank			Prince	e Geor	
Funera Directo		5	Social Security Number 213-46-6446	6. Sex 1 ☑ M 2 □ I		yrs. last birthda Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Oct. 9	, Year) 1947		lace (State or Foreign try) ington, DC
p .		-	sual Residence of Decedent Oa. State 10b. County		100	. City, Town or	Location				11	0d. Inside City Limits
sho			Maryland Prince	George	S		Greenbe.	lt				1 ☐ Yes 2 🎇 No
with the N a or 28e-1	Disposit Dispositor	1	0e. Street and Number 6K Research Roa				10f. Zip Code 20770			10g. Citizen of U.S.A		try?
r death v	i caro	1	1. Marital Status	12. Was D	Decedent Ever	in U.S.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Bla	ce - Americ ack, White,	etc.
5-UUSO 72 hours after natural, or but a local Examination in the local Examination is a local Examination in the local Examination in the local Examination is a local Examination in the local Exam	1	2	1 Never Married 2 Marriad 3 Widowed 4 Divorced		es 2 V No Give or Dates:	16a De	1 Yes 2 No	Specify:		Special Specia	Mhite	
Z I 3-1 ithin 72 h ien "natu i Wedica		Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t grade complet	ed) ge (1-4or 5+)	(G	ive kind of work done for DO NDT use retired y Laborer	during most of wor	rking	Archit		f the
nd ZI be filed wi al Hygien tother th		ם ב	12th 17. Father's Name (First, Middle,			Da	у паротет		ne (First, Middle,	Maiden Suma	me)	01
VIAI ould to Ment Markec	1	2	Francis DeSa			19h M	failing Address (Street		ngelina l ural Route Numbe			Code)
Maryland of 2 should be fill th and Mental Hy 27 is marked oth			19a. Informant's Name/Relations Kimber1y Cragg				17 Summer					
ges 1 and of Healt in the Healt or other		- 1-	20a. Method of Disposition 1 Burial 2 Decremation 4 Donation 5 Other (S		2		isposition (Name of crematory or other pla	_{сө)} Jun	e 16,	20c. Location	,	own, State aryland
Baitimore, IMaryliand ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: It item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treaumatic event, the Mardical Examination unities notified at	nce.	T	21. Signature of Funeral Service			ee Cre	22. Name and Addre	ess of Facility Le	ee Funer	al HOme	, Inc	n, MD20735
4 4054	a	+	23a. Part1. Enter the disease, o shock, or heart failure. List	complications to	nat caused the on each line.							Approximate Interval Between Onset and Death
Pnysicia /Medic			Immediate Cause (Final disease or condition resulting in death)	- 2	Cardion e to (or as a co		y, Ischemi	С				
Examin		-	Sequentially list conditions,	h .	Cardiac e to (or as a co	Arryt	hmia					
acuted and transit		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a co	nsequence of	ı:					
8760, ate be executed hysician and the burial-transit		icai E)		d	0.0 (0. 20 20 30							
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and sone 2 should be death-had for use as the builds traditional.	200	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 OL	s, outcome of pive birth 2 Pregnant at tim	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су			Date of deliv Month	rery Day Year
ds, P. Lires that the signed by the detail		ò	Part II. Other significant condit Multiple CVA					iven in Part I.				the cause of death?
Records, The law requires to the has been signed and the law required to the law required has been signed by the law red to th	000	Completed	HTN (Hyperte						24a. Was auto perf	s an 24b opsy ormed? 20 No	death?	opsy findings available ompletion of cause of
	rector, p	0	25. Was case referred to medic	al					eath (Check only	one)		
	0	10 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 Yinpatient	2 ER/Out	batient 3 DOA		Home 5 Res	how injury occ		ify)
ing Phy	unera		27. Manner of Death 1 X Natural 5 ☐ Pend	ing	Date of Injury (Month, Day Y	ear) 28b. Ti	jury W	ury at ork? □Yes 2□No	200. Describe	now injury occ	unou	
Division of or Attending after death. Director: After	n by the r	Certification:	3 Suicide 6 □ Could	minad 200.	Place of Injury building, etc. (- At home, fari Specity)	n, street, factory, office			(Street and Nui own, State)	nber or Rui	ral Route Number,
Division To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After	aly filled i	edical Ce	(Check only 2 Medics	I Examiner: On	the basis of ex	camination and	death occurred at the /or investigation, in my	opinion, death occ	curred at the time	, date and plac	o, and dad	10 11.0 00000(0)
thin 2	mplet	Med	one) 29b. Signature and title of certif	er	I manner state	u.	29c. Licer	nse number		29d. Date sig	ned (Month	i. Day, Year)
TW	8		> Chalab	C BE	212ing	MA	DO	0569	86	06/0	9/05	-
4 1	1		30. Name and address of person	n who completed	d cause of dea	th (Item 23a) (Type, Print)	. 1			COL	CEENBELT,
20			CHALAK BE	ELZIN	61 H.	8. 750	O HANDUEL	L TARKW	AY SUI	75-105		4020772
Re	Sta gístr		31. Date filed (Month, Day, Yea JUN 1 4	2005	32. Hegistrar's	B. Grature	or and a second					CEENBELT, HDJO:772

	•	For State Registrar	State of	Marylar			of Health of Death		lental Hyg	iene 005	19745
Physicia		Decedent's Name (First, Middle Marvin	Last)		Fe	nno			2. Date of Deat Month JUNE 10,		3. Time of Death 10:30 P M
/Medic Examin		4a. Facility Name (If not institution,		ber)		1	wn, or Location			4c. County of De	ath
		CIVISTA MEDIC	AL CENTER			LAPL				CHARLES	
Funeral Director		5. Social Security Number 215–38–5813	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Y Months D		er 24 Hrs. Min.	8. Date of Birth (Month, Day, March 3	9. B 0,1916 Ma	irthplace (State or Foreign Country) rvland
	-	Usual Residence of Decedent				1				0,1210,110	
show	5	flaryland Prince	George's	10c. Cit	ty, Town or Lo		0.70.0				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Directo	10e. Street and Number	George S		opper	Marlb			1	0g. Citizen of What (Dountry?
3a or	ā	11220 Fen	no Road			20	772			U.S.A.	
death	nera	11. Marital Status	12. Was Dece		J.S. 13.			Origin? (Spe	ecify Yes or No- Rican, etc.)		nerican Indian,
or Its	by Funerai	1 Never Married 2 Marri	ed 1 □Yes If Yes, Give	2X No		1 □ Yes 2 %				Specify: W	
ture!		3 ₩ Widowed 4 Divorced 15. Decedent	Year or Da	tes:	16a Dece	dent's Usual C	Occupation			16b. Kind of Busines	
n "na"	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	40r F 1\	(Give	kind of work of DO NOT use i	done during mo retired)	ost of work	ing		·
d with giene	Com	8th	College (1		Farm	er				Fenno Fari	n
all de file natal Hy ed other	Be	17. Father's Name (First, Middle, Henry Harris					18. Mot		e (First, Middle, I Sie A. B	Maiden Sumame) ea11	
should Me mark	2	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (S	Street and Num			; City or Town, State	, Zip Code)
y IVIC		Jean M. Locan	tore (Daug							icsville,	
ages 1 a ant of Hea it: If Item y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S)		State Br	Place of Dispo cemetery, crea OOKTIC	nsition (Name matory or othe Lf Un.	Meth.	Ch. (em.	20c. Location · City of Upper Mari	
pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, if a Medical Examinar must be nettined at once.		21. Signatury of Funeral Service		m0025						al Home, I	Inc. con, MD20735
		23a. Part1. Enter the disease, or	complications that ca	used the dea							Approximate Interval Between
Physician		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	eps	رة						Onset and Death
/Medical Examiner			Due to (or as consec	quence of):						
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
OX OX / OU, certificate be executed rding physician and ise as the burial-transit	al Exa	that initiated events resulting in death) Last	C	or as a consec	quence of):						
cate b	.2		d								
OX O	ician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn inth 2 ☐ Fet		⊒Ectopic preg				23d. Date of d	*
death death od for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of		Other (spec				Month	Day Year
Ords, F.O. requires that the een signed by th hould be detache	by Ph	Part II. Other significant condition	ons contributing to de	ath but not re	sulting in the u	underlying cau	ise given in Pai	rt I.	23e. Did to	bacco use contribute	to the cause of death?
COLOS w requires been sign should be		per speral	- Voy(a	lin	1) ; se	ore,			1 🗆 Y	es 2⊡No 3□	Probably 4 Unknown
O ≥ 0 0	ompleted	1 Dichetes	Hell ;)	tus,		0			24a. Was a autops	sy prior t	autopsy findings available o completion of cause of
Page Th	O	Chronic	06517	uetiv	e po	Show	ory 1	سنصر کی ا	Ves □ Yes	2₫ No 1□Y	
OT VICA Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	anationt 2	ER/Outpatie	nt 3□ DOA	Star		h (Check only or	ne) ence 6 ∐Other <i>(S</i> i	pecify)
	-	27. Manner of Death	28a. Date	of Injury h, Day Year)	28b. Time o		c. Injury at Work?	rear saring the		ow injury occurred	,,,,,,
Attending r death. sctor: After by the fune	atio	1 Vatural 5 Pendir 2 Accident investi	gation	ii, Day Toary	mjury	М	1 ☐ Yes 2	□No			
DIVISIO DI or Attend after death I Director: ,	ertification;	3 Suicide 6 Could 4 Homicide	inod 280. Flace	of Injury - At h ng, etc. (Spec	home, farm, st ify)	reet, factory, o	office		28f. Location (S City or Tow		Rural Route Number,
Hospite 4 hours Funerel ely fille	edical C	(Check only 2 Medical	Examiner: On the ba	asis of examin						ause(s) and manner late and place, and d	
To the within 2 To the complet	Med	one) 29b. Signature and title of certifie	1	ner stated.		29c. l	License numbe	er e	2	29d. Date sigged (Mo	nth, Day, Year)
× 3 + 8)	In	Su	س		D-371	174		6/11	105
4		30. Name and address person				, Print)	one er	s some	TV Street and	00000	
Sta	ite	SONG C. CHON M 31. Date filed (Month, Day, Year)	#. R	egistrar's Sigr	nature	C FUST	OFC RI	. WAI	DORF, MD	ZUOUZ	
Registr		JUN 14	2005	w D	April	N. S. S. S. S. S. S. S. S. S. S. S. S. S.					

			For State Registrar		State of	Maryland	-	artment rtificate			nd Mer		giene Reg. No.	005	19746
ı	Physici	an	Decedent's Name (Firs EDEDEDE TOTAL				T					Date of Dea Month JUNE {		005 Year	3. Time of Death
	/Medic Examin	al	FREDERI 4a. Facility Name (If not in JOHNS HOPK	nstitution, give			IKOWS	4b. City, T		Location of	Death	JONE (County of Death	5:28 P M
	Funeral Director		5. Social Security Number 212-56-36	1 9 6. Se		. Age (In yrs. I	ast birthday) Yrs.	If Under 1		If Under 24 Hours	4 Hrs o	Date of Birt (Month, Day DEC •	h y, Year) 24, 1	O Dieto	alace (State or Foreign ntry) RYLAND
	show ed at	or	Usual Residence of Dece 10a. State 10b. MD •	County	IMODE		, Town or Lo							1	0d. Inside City Limits
	the M	rect	10e. Street and Number	DALI.	IMORE		DUNDA	10f. Zip (Code				10g. Citiz	zen of What Cour	ntrv?
	th with	al Di	2912 LIBE	RTY P	ARKWAY	APT.	D		212:	22				U.S.A.	•
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-1 show other treumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 X		12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? XNo		Was Decede If Yes, speci 1 Yes 2		spanic Origi n, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		14. Race - Americ Black, White,	
215-0036	2 hour	ted t	15. C	Decedent's Ed	ucation		16a. Dece	dent's Usual	Occupa	tion			16b. Kir	nd of Business/Inc	
21215	filed within 7: Hygiene. other then *n ant, the Medi	Completed	(Specify on Elementary/Secondary 9		de completed) College (1-	4or 5+)		kind of work DO NOT use SABL		uring most o	of working			N/A	
pu	be filed tat Hygid d other	Bec	17. Father's Name (First,							18. Mother	s Name (Fi	irst, Middle,	Maiden :	Sumame)	
Maryland	2 should be fand Mental Fis marked of eumatic ever	To		FREDE		AIKOW			(011-	LILL				ROWSKI	0-41
Mai	th and th and then treun		19a. Informant's Name/R			ית איי								Town, State, Zip	
	ges 1 and tof Health If item 27 or other tr		20a. Method of Dispositio	on		20b. PI	lace of Dispo	sition (Name	e of		Date			cation - City or To	
Baltimore,	Page nent o ant: If ary or		1 X Burial 2 ☐ Cre '4 ☐ Donation 5 ☐ € 21. Signature of Funeral	Other (Specify	')		STAN	ISLA	US C	CEM.					MARYLAND
Ba	permit. Departr Imports any inju		21. Signature of runeral	Service Elcen	To the	The second		ILLY 901 I	& 2	ZEILE	RIN	C. FU	UNER	RAL HOM	E D 21221
			23a. Part1. Enter the dis	ease, or comp	olications that car	used the death								MORE, M.	D. 21231 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ire. List only		osclenot	ric c	andio V	asci	ular	dise	ise			Onset and Death
ı	/Medical Examiner		resulting in death)		a	r as a consequ									
	Exammer	_	Sequentially list condition if any, leading to immedia	ns,	b. Due to (e	r as a consequ	ionoo of):								
V	nted Insit	Examiner	Cause. Enter Underlying Cause (Disease or injury	ate		as a consequ	erice oi).								
8760,	be executed sician and burial-transit		that initiated events resulting in death) Last		c. Due to (o	r as a consequ	ience of):								
687	ificate I g physi	edica			, d										
. Box	The law requires that the death certificate be executed to be associated as been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown	Hant		th 2□Fetal nt at time of de	death 3[Ectopic pre Other (spe					2	3d. Date of delive Month	ery Day Year
, P.O	res that the de igned by the be detached		Part II. Other significant	conditions c	ontributing to dea	ath but not resu	ılting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco us	se contribute to th	ne cause of death?
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of		To To	1 XYes 2 No 27. Manner of Death		28a. Date of	Injury	ER/Outpatier 28b. Time o		A Bc. Injury Work	4 14015		5 Resid		☐Other (Specify coccurred	γ)
ion	Attending Isr death. ector: After by the funer	atlor	1 Natural 5 2 Accident	Pending investigation		, Day Year)	Injury	М		? ′es 2 ☐ No	0				
Division	5 J. j. c	Certification:	3 Suicide 6 Homicide	Could not be determined	280. Place C	of Injury · At ho g, etc. (Specify	me, farm, sti	eet, factory,	office		28f.	Location (S City or Tow	Street and m, State)	d Number or Rura	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filted in by	edical (sis of examinat								and manner as si place, and due to	
	To the within To the	Me	29b. Signature and title o	of certifier				29c.	License	number			29d. Date	e signed (Month,	Day, Year)
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	2		30. Name and address of	r LI	, MID	or ueam (nem	-ua) (1ype,	111	Penn	Stre	et B	altim	ore.	Marylan	d 21201
	Sta Registr	ite ar	31. Date filed (Month, Da	y, Year) N 1 4 2	005 32. Re	gistrar's Signat	erue							<u>v</u>	
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				For State Registrar		State o	of Mar	-	-	rtment of Health		ntal Hy	gier Reg. i	601)5	19747	
				1. Decedent's Name	(First, Middle, Las	t)						Date of D Month		Day	Year	3. Time of Death	
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		death me 2	Funeral Director	11. Marital Status	ich onoic	12. Was Dec		er in U.S.	13. V	Vas Decedent of Hispanic C Yes, specify Cuban, Mexic	Origin? (Specify	Yes or N	lo-	14. Ra	ce - Americ ck, White,		-
	36	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "neturel", or Iteme 23e or 28e-f show appringing or other traumatic avent, I're Medical Exite national be mailled at an once.	y Fu		ed 2 Married	1 ☐ Yes If Yes, Gi	2 ₹ No			Yes 2 No Special		un, 010.7			ý: Whi		
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No	Baltimore, Maryland 21215-0036	d 2 sh th and t7 le n traun			ame/Relationship (i Land (dau	• •				Oak Grove Ci				•			
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_						olications that one cause on	each line	he death. Do n	ot ente	er the mode of dying, such a	as cardiac or re	spiratory	arrest,			Approximate Interval Between Onset and Death	
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(9)		res th	ρχ	Part II. Other signi	icant conditions o	ontributing to o	death but	not resulting in	the un	iderlying cause given in Pa	π ι.			2□No	3 □ Prob	2.7	
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N	of Vital Records,	iling Physicien: Tha lav n. After this certificate has funeral director, page 2	e Co	25. Was case refer	red to medical					26 Pla	ace of Death (C		-	No	1 🗌 Yes	2 ∐ No	
3	>	Physicien: this certific ral director,	O B	examiner?		Hospital:] Inpatien	t 2 ER/Out	tpatient		Nursing Home			6 6 Ott	her (Specif	y hospice	
0	ō	ng Ph ter th neral	n: T	27. Manner of Deal	th 5 Pending	28a. Date (Mor	of Injury	28b. T Yea <i>r)</i>	ime of					njury occu	rred		
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lad Kows	Division	al or Attending F s after death. Il Director: After ed in by the funers	Certification:	4 Homicide	determined	286. Plac	e of Injur ding, etc.	y - At home, far (Specify)	rm, stre	eet, factory, office	281.	City or T	own, S	tate)	ber or Hura	al Route Number,	
0	ш	To the Hospital or Attending Physicien: Tha law within 24 hours after death. To tha Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier	Certifying Ph	vsician: To th	e best of	my knowledge	, death	occurred at the time, date	and place, and	I due to th	e cause	e(s) and m	anner as s	tated.	
2		ne Hos	edicai	(Check only one)		niner: On the		examination and		estigation, in my opinion, o							
		To th withir To th comp	M	29b. Signature and	title of certifier	1				29c. License numbe			29d.	Date signe	ed (Month,	Day, Year)	
	•	,			Mar	lu	S			DS83	202		ال	INC	11 0	03	
		6		30. Name and add	ress of person who	completed cau	se of de	ath (Item 23a) (Туре,	DS83	Drive	m. L	w	2/2	04		
			ate	31. Date filed (Mor	oth, Day, Year)	32.	Degistrar	's Signature	/- C	vuotes 1					/		_
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Physician /Medical **Examiner** burial-transit Box 68760, The law requires that the death certificate be AMRRIVE

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Records,

Division of Vital Hospital or Attanding Physician: the a

has

certificate

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After

within 24 hours after death. To the Funeral Director: A

Immediate Cause Final disease or condition resulting in death) Examiner Physiclan/Medical signed by the þ Completed 25. Was case referred to medical examiner? Be 27. Manner of Death Certification; 29a. Certifier Medical

1 - For State Registrar

Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ø No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema,

3 Ectopic pregnancy 5 Other (specify)

SeveRE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ZYes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

3. Time of Death

1305 M

N/A

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 ☐ No

9. Birthplace (State or Foreign

Maryland

14. Race - American Indian, Black, White, etc.

White

00

IISA

Specify:

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier m3

BRONCHOPNEUMONIA

investigation 6 Could not be determined

> 29c. License number 66982

29d. Date signed (Month, Day, Year)

900 CATON AUE BALN'MORE MODIZING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MilleR MA JOSEPH 31. Date filed (Month, Day, Year)

and manner stated.

State Registrar

1 ☐ Yes 2 No

1 Natural
2 Accident

3 🗌 Suicide

4 Homicide

(Check only one)

Stewn & Sperle

State of Maryland / Department of Health and Mental Hygiene 0.05Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month TRACY JEAN GROSS June 10 2005 12:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9508 Jeanne Court Laurel Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 9, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F 277-88-3036 Yrs 31 1974 Connecticut Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 X No Directo MD Howard Laurel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9508 Jeanne Court 20723 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Market Research Billing Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George K. Horch Kathleen T. Carves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9508 Jeanne Court, Laurel, MD Anthony D. Gross/Husband 20723 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery 6/13/2005 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Inter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one surse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTA disease or condition resulting in death) Due to (or as a consequence of): YEARS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARCINOMATOUS MENINGITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 212 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6-13-05 D42403 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 IRVING STREET, WASHINGTON D. C 20010 MATHUR RAJ 32. Registrar's Signature Registrar

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

with the Maryland

filed within 72 hours after death

al Hygiene.

or other traumatic event,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ta marked oth any july or other traumatic event 2008.

Physician

/Medical

Examiner

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funeral director,

filled in by the

completely

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The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:05 A M June 9 2005 Dorothy E. Gurny /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 311 Jerlyn Avenue Linthicum Heights | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Feb. 12,1923 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2⊠F Vrs Maryland 82 219-12-8794 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or itams 23a or 28e-f show any injury or other traumetic event, the Medical Examinat must be rudified at once. 1 ☐ Yes 2 No Director Linthicum Heights Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 U.S.A. 311 Jerlyn Avenue Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nellie Potts John Prestley Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Gurny (Daughter) 126 East Churchill Street Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Arlington National 6-30-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature Funeral Servic Censee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Onset and Death POLY CYTHEMIA Immediate Cause (Final YEARS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Indentying Cause (Disease or injury b. Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITUS DIABETES 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 sidence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. injury at Work? Certification: al or Attending P s after death. il Diractor: After ed in by the funer: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To tha Funaral D Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO031563 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Item 23a) (Type, Print)
1080 (LOCKWOOD PRIVE #205, SILVERSPRING, ND) CHARLES M. BENNER, MD 31. Date filed (Month, Day, Year) 3 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of	Maryland		irtment of H tificate of I			ene2 () () 5	19751
	1. de		Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)		Cei	uncate of i	Jealii	2. Date of Death	g. No.	3. Time of Death
	Physicia	an		gannon					Month June	9 2005	7:30P M
	/Medic Examin		4a. Facility Name (If not institution, give		oer)		4b. City, Town, or	Location of Deat		4c. County of Death	
	LAGITIII		122 Starhill Lan				Caton	sville		Baltimo	re
	Funeral		Social Security Number 6. S		Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birth	nplace (State or Foreign untry)
	- Director		217-10-2930	☐ M 2 🔯 F	8	7 Yrs.	Wichians Days	riours iviiii.	Sept. 7,	1917 Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Manyl f sho	o	Maryland Baltimo	re		Caton	sville				1 ☐ Yes 2 ☒ No
	r 28a	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
	h with	ai D	122 Starhill Lan	e			212	28		U.S.A.	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is markad other than "natural", or itams 23c or 28a-f show other traumatic evant, it e Modical Examinatings and it is a mortified at	Funeral	11. Marital Status	12. Was Deced Armed Force	ent Ever in U.S	S. 13. V	Vas Decedent of H	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
0	or its		1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	⊠ No		☐Yes 2X No	Specify:	,,	Specify:	
Š	hours tural!	ed by	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Date	es:	160 Doors	lent's Usual Occup	ation	1	6b. Kind of Business/I	hite
2	in 72 in " n	Completed	(Specify only highest gra-	de completed)		(Give	kind of work done of NOT use retired	during most of wo	rking	ob. Killa of Busilessyl	ridustry
7	d with piene. r thau	mo	Elementary/Secondary (0-12)	College (1-4	(or 5+)		Homemake:			Own H	ome
-	e filed within al Hygiene. I other than "vant, it e Ma	0	17. Father's Name (First, Middle, Last)						me (First, Middle, M		
yland	should be ind Mental s markad o umatic eva	To B	Harry O. Dubner					There	sa Blumen	auer	
al	2 sho and I is me		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Number,	City or Town, State, Z	ip Code)
≥ ″	1 and Health tam 27 other tr		Mark Gannon (Son)	ook B		tarhill 1	Lane Ca		, Maryland	
0	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Removal from St	ate Cé	emetery, cren	sition (Name of natory or other place			Oc. Location - City or	
pairimor	t. Pa tmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Specify		Lou		rk Cemet	-	3-05 B	altimore,	Maryland
מ	permit. Pages Department of Important: If is any injury or o		21. Signatura — unerai Service i 4n	500	110129	Wi	. Name and Addres	eral Ĥom	e of Cato	nsville, I	nc.
	* %:/		23a. Part1. Enter the disease, or comp shock, or feart failure. List only Immediate Cause (Final	plications that cau	used the death	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arres	sville, MD st. Didense	Approximate
	Pnysician /Medical		disease or condition resulting in death)	a Que to (or	r as a consequ	ience of):	CAN	1,60,00	> 1100 110 E V= ((7000	4000
	Examiner		One of the Property of the Control o	Chron	ni Or	Strass	E pulmi	nary I	Aflore		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequ	ience of):	*				
1	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (o							
Ď,	be ex cian burial	cai E		Due to (o	r as a consequ	ence or).					
00/00	certificate be executed nding physician and use as the burial-transi	edica		3							
C. BOX	death certi e attending od for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩6 9 □ Unknown		h 2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Ţ	that the	by Ph	Part II. Other significant conditions of	ontributing to dea	th but not resu	Ilting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
2	requires neen sign hould be								122 ¥es	s 2□No 3□Pro	bably 4 DUnknown
Hecords	ilcian: The law recertificate has bee	Completed							24a. Was an autopsy perform	ed? prior to death?	topsy findings available ompletion of cause of
VIIai	an: T	0	25. Was case referred to medical					26. Place of De	1 ☐ Yes 2 ath (Check only one		2010
	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Ing	patient 2 1	ER/Outpation	t 3 DOA Oth	er: 4 Nursing I	Home 5 Hesider	nce 6 Other (Spec	rify)
lon or	nding Phys ath. r: After this e funeral di		27. Manner of Death 1 Autural 5 Pending 2 Accident Investigation		Injury Day Year)	28b. Time of Injury	28c. Injun Wor M 1 🗀	yat k? Yes 2 □ No	28d. Describe how	w injury occurred	
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Surcide 6 Could not be 4 Homicide determined	289. Place 0	f Injury - At ho g, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	na Hospital or At n 24 hours after o na Funaral Diraci bletely filled in by	edical (is of examinat					use(s) and manner as te and place, and due	
	To the within To the comple	M	29b. Signature and troe of certifier	(Can	2		29c. Licens			d. Date signed (Month	
	\wedge		30. Name and address of person who	completed cause	of death (Item	233) (Type,	Part el t	nd (03	Cohm	Chan,	1225
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2005	32. Re	gistrar's Signar	docut.	e e				
			<u> </u>	- PERSONAL PROPERTY.							

		1	For State Registrar	State of M	laryland	-	artment of H			giene))	5 19752	
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	3. Time of Death	
	Physicia		Thomas Lee Gentry						June 9	,	5:50 P M	
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of Death		4c. County of		
	Lamin	31	3103 Rolling Green Drive				Church	ville		Harford		
	Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th Year)	9. Birthplace (State or Foreign Country)	
	Director		216-10-0832	XXM 2□F	93	Yrs.	World's Days	Hours Will.	Sept. 1		North Carolina	
	D >	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Fown or Lo	cation				10d. Inside City Limits	
	shov	2	,								1 ☐ Yes ŽÕ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, It is Madical Exact indicates in any injury or other traumatic avant, It is Madical Exact in all the Incillia of all once.	Director	Maryland Harford Churc				10f. Zip Code			10g. Citizen of Wh	net Country?	
		급	3103 Rolling Green Drive				210	20		USA		
21215-0036		era	11 Marital Status 12. Was Decedent Ever in U.			S. 13. Was Decedent of Hispanic Origin? (Sp			pecify Yes or No		- American Indian,	
		by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes, 2 Mo 3 Widowed 4 Divorced Year or Dates:		X No	If Yes, specify Cuban, Mexican, Puerto			Rican, etc.)	etc.) Black, White, etc. Specify: USA		
		Completed I	15. Decedent's Education			16a. Decedent's Usual Occupation				16b. Kind of Busi		
			(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of work life. DO NOT use retired)			king	ng		
		E O	12			Owner/ Operator				Construction		
		To Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam			e (First, Middle, Maiden Surname)			
Maryland			Charles Wesley Gentry				Minnie			u/k Wilcox		
ar			19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a	and Number or Ru	rai Route Numbe	er, City or Town, S	tate, Zip Code)	
			Thelma W. Gentry	<i>y</i> - Wife				Green Dr:			e, MD 21028	
ore			20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3	☐Removal from Stat	сел	netery, crei	sition (Name of matory or other plac		Date		City or Town, State	
Baltimore,			' 4 ☐ Donation 5 ☐ Other (Spec	cify)	Chur		lle Pres.		ALCOHOL: L		lle, Maryland	
			21. Signature of Funeral Service Lic	ensee			2. Name and Addres 317 Cokes				Home, P.A. cyland 21009	
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		23a. Part1. Enter the disease, of the plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
			Immediate Cause (Final disease or condition	Chr	onic	065	truct. Ve	- Polmi	nery	Disease	Onset and Death	
			Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstruct. Ve Polinicary Disease. Syears Due to (or as a consequence of):									
			Sequentially list conditions, b.									
		ine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent or as a cons									
		Examiner										
8760,		ᄪ										
687		ompleted by Physiclan/Medical		0.								
P.O. Box			IF FEMALE: 23b. Was decedent pregnant	ne of pregnanc 2 Fetal d	ancy Il death 3□Ectopic pregnancy				23d. Date Mont	of delivery th Day Year		
			in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ves 2 No 9 Unknown									
		y PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			
	quire on sig uld b	pa pa	- Coronary Artery Disease						1 Yes 2 No 3 Probably 4 Monknown			
00	aw re	plet	- Coronary Artery Disease - Malabsorption Syndrome.						24a. Was an autopsy findings avait prior to completion of cause		Pere autopsy findings available rior to completion of cause of	
Ä	9 P	Eo					_		perfo	ormed?de	eath?	
Division of Vital Records,	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate completely filled in by the funeral director, pag	Se C	25. Was case referred to medical 26. Place of Death (Check									
		To B	examiner? 1 Yes 2 No							r (Specify)		
		Cod Decade has fallen a							how injury occurre	d		
		atlc	2 Accident investigation				M 1 ☐ Yes 2 ☐ No			COLL TO STATE OF THE STATE OF T		
		Certification:								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		ledical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
		Medi	one) and manner stated.				29c. License number			29d. Date signed (Month, Day, Year)		
	To With	~	29b. Signature and title of certifier				A350/2			June 10, 2005 Bel Air, Md 21014		
	15		30. Name and address of person with J. Kevin	Cyruch	f death (Item 2	23a) (Type	Print) 2 NG/	tz A	ve.	BelA	ir, md 21014	
	State Registrar		J. Kevin Cruct no 2 North Ave . Bel Air, nd 21013 31. Date filed (Month, Day, Year) JUN 1 4 2005									

			State of Mary 1- State Registrar		epartment of Health Certificate of Deat	h	giene 005	19753
			Decedent's Name (First, Middle, Last)		1 -	2. Date of Dea Month		3. Time of Death
	Physicia /Medic		- ovence	Ga	rtner	June	07 200	
	Examin	er	4a. Facility Name (If not institution, give street and number) Northwest Hospital C	nter	4b. City, Town, or Location	or Death Mary lan	4c. County of Pea	ntre
	Funeral		5. Social Security Number 6. Sex 7. Age (In	n yrs. last birtho	day) If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of Birth	year) 9. Bir	thplace (State or Foreign
	Director		215-56-6457 1□M XXF Usual Residence of Decedent	87 Yr.	S.	May 5,		ington D.C.
	yland		10a. State 10b. County 10	Oc. City, Town				10d. Inside City Limits
	he Ma 18a-fs	ector	Maryland Baltimore County		Windsor Mill		10-02	1 ☐ Yes 2 X X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Eran, at must be routified at once.	by Funeral Director	10e. Street and Number 5525 Old Court Road		10f. Zip Code 21244		10g. Citizen of What Ci USA	ountry?
	er deal	uner	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Ame Black, Whi	
036	urs afte	by F	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X X No 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:		1 ☐ Yes 2 X No Speci	fy:	Specify:	white
21215-0036	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	((ecedent's Usual Occupation Give kind of work done during m	ost of working	16b. Kind of Business	/Industry
121	within iene. than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	- 1	ife. DO NOT use retired) N/A		N/A	
nd 2	al Hyg al Hyg sother	BeC	17. Father's Name (First, Middle, Last)		18. Mo	ther's Name (First, Middle,	Maiden Surname)	
<u>y</u> a	Ment Ment narked	2	Unknown	105.1	Mailing Address (Street and Num	known	. Oh T Ch.	7:- 0
Maryland	nd 2 shallth and 27 is n		Johnetta Cheatham (P.R.)		O Rumsey Road			045
Baltimore,	ges 1 a t of Hea If item or othe		AVVoint of Commettee 2 Demonal from State	cemetery,	hisposition (Name of crematory or other place)	Date Date	20c. Location - City or	
E E	artment ortant: injury		`4 □Donation 5 □Other (Specify) 21. Signature of Funeral Sequide Livensee	Meadowr	idge Memorial		Elkridge,	
Ba	Depire Impo		Seau H. Cupenter		22. Name and Address of Fac Burgee-Henss-3 3631 Falls Roa	Séitz Funeral ad Baltimore	Home, Inc MD 2121	i
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart fathure. List only one cause on each line.	e death. Do no	t enter the mode of dying, such	as cardiac or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	oper	toneum			
В	Examiner		Bowel	Insequence of	Farch oni			
	sit	lner	Sequentially list conditions, if any, leading to fine addate cause. Enter Underlying Cause (Disease or injury	onsequance of)				
Ć,	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a c	onsequence of)):			
38760,	ate be nysicia he bur	dlcal	d					
-	certifica inding pl use as t	a a	IF FEMALE: 23c. If yes, outcome of	nragnancy			22d Date of de	throw.
Box	atte for	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at tim	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	Day Year
P.O.	the y th	Phys	9 ☐ Unknown					the same of death 0
	ngi be	by	Part II. Other significant conditions contributing to death but r	lot resulting in t	ne underlying cause given in Pa		bacco use contribute t es 2.₽No 3P	robably 4 Unknown
Records,	w requi	lete				24a. Was a		utopsy findings available
	The ate ha	Completed				autop perfor 1 ☐ Yes		completion of cause of
Vital	Phyaician: This certificate al director, p	Be	25. Was case referred to medical examiner?		Othor	ace of Death (Check only or		
of		n: To	1 Yes 2 No 1103plat 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Y	2 ER/Outp	ne of 28c. Injury at	Nursing Home 5 Resid	ence 6 LOther (Spe ow injury occurred	ecify)
sion	Attending r death. ector: After by the fune	atlo	2 Accident investigation	'ear) Inji	ury Work? M 1 ☐ Yes 2	□No		
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, fam Specify)	n, street, factory, office	28f. Location (S City or Tow	itreet and Number or R m, State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifying Physician: To the best of r					
	To the h within 24 To the F complete	Medi	one) and manner stated 29b. Signature and title of certifier A		29c. License numbe		29d. Date signed (Mon	
)	Son William		V fullaron		D0036			
7)		30 mame and address of person who completed cause of deal Patrica A. Melton M	10 :		819 curt Road	Rundalls	Fown MD 21133
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regulars's JUN 1 4 2005	Signature &	Sparker			

				For State Registrar	State of	Marylar		partment e ertificate		ealth and N Death	fental Hy	gien	. U U	5	19754	
				Decedent's Name (First, Middle, Lateral	st)						2. Date of De	aath			3. Time of Death	
		Physici	an	a)] =1.' 1		1					Month	Da	y 2005	Year	10:10 AM M	
		/Medic	3.5	Charlotte Elizabe 4a. Facility Name (If not institution, give				4h. City. To	wn or	Location of Death	June 1	-		of Death	1	_
		Examin	ier	Gilchrist Center			ro	AD. Only, 10					alti			
				5. Social Security Number 6. S		Age (In yrs.		(v) If Under 1		owson If Under 24 Hrs.	8. Date of Bi			9. Birtho	olace (State or Foreign	
		Funeral Director			□M 200 F	93	Yrs.	Months [Days	Hours Min.	8. Date of Bi (Month, Date 12/06)			Cour M D	ntry)	
				Usual Residence of Decedent							12/00/	191.	1 1	עוי		_
		yland yland		10a. State 10b. County		10c. Cit	ty, Town or	Location						1	10d. Inside City Limits	
		Man Feet	to	MD Baltimo	re	Ess	sex								1 ☐ Yes 2 No	
		1 the	Director	10e. Street and Number				10f. Zip C	ode			10g. Ci	itizen of \	What Cour	ntry?	
		3a o	Ō	1811 Elk Road				2122	1			Uni	ted	State	es	
		within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ta M. Jical Ex. uither i, ust b. nutflied a	Funerai	11. Marital Status	12. Was Deced	ent Ever in U	J.S. 13			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N		14. Rac	e - Americ	can Indian,	
Z	ယ	or Ita		1 Never Married 2 Married	Armed Forc	No No		1 ☐ Yes 2			Hican, etc.)			ck, White,	etc.	
4	93	urs all, o	Completed by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1 LI Yes 26	<u>M</u> NO	Specify:			Specify	Whit	e	
	9	2 ho satur	ted	15. Decedent's Education (Specify only highest gra	ducation		16a. Dec	cedent's Usual	Occupa	ation Juring most of work	ina	16b. F	Kind of B	usiness/In	dustry	
1001	2	Pin 7	pje	Elementary/Secondary (0-12)	College (1-4	or 5+)	life	DO NOT use	retired,)	,,,g	Hea	lth	Care		
	21	d wit	NO.	9			Tele	phone C	per	ator						
9	Þ	othe vant,	Be C	17. Father's Name (First, Middle, Last,)					18. Mother's Nam	e (First, Middle	e, Maidei	n Suman	ne)		
60/	<u>lar</u>	utd b Aentz rked tic a	ToE	Harry Rich Gorge,	Sr.					Louise	Woolshl	eger				
	Maryland 21215-0036	should have a man	-	19a. Informant's Name/Relationship (Турв, Print)		19b. Ma	ailing Address (S	Street a	nd Number or Rui	al Route Numb	er, City	or Town,	State, Zip	Code)	
-	Σ	alth a 27 l		Gloria Trombero /	Daughte	r	181	1 Elk R	oad	Essex, N	ID 2122	1				
11/10	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Model Exeminer must be notified at once.		20a. Method of Disposition	_	20b. I	Place of Dis	sposition (Name rematory or oth	of er place	9)	Date	20c. L	ocation -	City or To	own, State	
	9	Page ent o nt: ff ry or		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Specif		9/8		ake Cre			Jun 13 2005	Bel.	tsvi	lle, 1	Maryland	
	Ħ	nit. F artm ortar injui	. 1	21. Signature of Funeral Service Lice		189001		22. Name and			2003				-	
#	B	Dep Imp any		18 the						nd Funera				. Wa	1 o d	
\$7#¢				23a. Part1. Enter the disease, or com	plications that cau	sed the dea				Pastures g, such as cardiac			THOLE	е, ма	Approximate	П
ಕ 🗸		-000		shock, or heart failure. List only Immediate Cause (Final	one cause on eac	th line.									Interval Between Onset and Death	
2		Pnysician /Medical		disease or condition resulting in death)	a. Nev		regle	ste	بان	<u> </u>				(days	
C		Examiner			Due to (or	as a consec	quer = of):								v	
.0			<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	nuence of):					-		-		_
ORSKI	A /	ed Isit	Examiner	cause. Enter Underlying Cause (Disease or injury	240 (0)	45 4 5011500	4401100 01).									
S	4	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c	as a consec	guence of):		-					-		-
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+	58760,	cate be executed physician and the burial-transit	dicai		d				-							
S	9 x	ertification of the seas		IF FEMALE:	23c. If yes, outco	ome of pregn	ancy/						00 t D			
10	Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	h 2 Feta	al death	3 Ectopic preg						ite of delive onth	ery Day Year	
\mathcal{C}	0	the a	/sic	1 Yes 2 No	4∐Pregnai 9☐ Unknov	nt at time of o	death :	5 🗌 Other (spec	ciry)							
	P.0	d by Hetac	by Physician/Me	Part II. Other significant conditions	contributing to dea	th hut not rec	sulting in the	e underwing cal	ISO CIVA	on in Part I	23e. Did	tobacco	use conf	tribute to t	he cause of death?	_
	S,	res th		Fait II. Other significant conditions	contributing to dec	an Dat not 16.	Sulling in the	a undanying cac	Joe give	arnir arti.				3 Prot	~1	
	oro	een s	ted													_
	Division of Vital Records,	law lasb	ompieted								24a. Wa auto	psy		prior to co	opsy findings available empletion of cause of	9
	α.	The ate h page	Con								1 ☐ Yes	ormed?		death?	2□ No	
	ita	ian: artific ctor,	Be (25. Was case referred to medical examiner?						26. Place of Dea	th (Check only	one)				
	÷	nysic nis ce dire	2	1 ☐ Yes 2 S No	Hospital: 1 1 In	oatient 2	ER/Outpat		1	4 Nursing H	ome 5 Res	idence	6 2 0th	ner (Specif	m hespua	
	0	ig Pt ter th		27. Manner of Death 1 → Natural 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time Injur	e of 280	c. Injury Work	at	28d. Describe	how inju	ary occur	red		
	0	ath. r: Af	atic	2 Accident investigation				М		Yes 2 □No						
	<u> </u>	Atte	iji	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace 0	f Injury - At h	nome, farm,	street, factory,	office		28f. Location City or To			oer or Rura	al Route Number,	
		s afte	Certification:			,, (
		To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	icai (ne, date and place, pinion, death occur						
		he Hin 24 ha Fi	ed	one) 2 Medical Exa	and manne		and and of				TOU AL LITE LITTE					
		To t withi To tl	Σ	29b. Signature and title of certifier						number					Day, Year)	
				()/Kleil	us			1	155	3303		777	ve (1	120	107	
		\wedge		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Typ	pe, Print)						Δ =		
		(elesur)	66	201	N. ()	h	3303 oplei S	1 20	120	70	2 (m	izoy	
		Sta	ate	31. Date filed (Month, Day, Year)	1	gistrar's Sign	nature									
		Regist		JUN 1 4 2005	Block	gistrar's Sign	Spa.	We I								
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		1 - State Registrar		Marylar		artmen rtificat				ental Hyg	giene Reg. No.	005	and the state of t	9755
Physic	ian	Decedent's Name (First, Middle	· ·							2. Date of Dea Month	ith Day			3. Time of Death
/Med	ical .	Elfriede Gilb 4a. Facility Name (If not institution,		harl		45 035	T	r Location		JUNE			05	1:33 pm
Exami	ner	ST. AGNES	HEALT)		E	40. City,	Λ		m D R	E	40.	County of E	eatn	
Funera			6. Sex 7		last birthday		1 Year	If Under		8. Date of Birth (Month, Day	h Name	9.	Birthpla	ice (State or Foreign
Director		218-60-7300	1□M 2₹F	70	Yrs.	Months	Days	Hours	Min.	June 1 ,	, rear) 193	35 G	erm	
pur *		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ity, Town or L	ocation							110	d. Inside City Limits
Maryli f sho	ō	MD			17711	imore							10	1 ☐ Yes 2 ☐ No
death with the Maryland ms 23a or 28a-f show rmust be notified at	Completed by Funeral Director	10e. Street and Number			Dare	10f. Zip					10g. Citiz	zen of What	Count	
66 after death with or Itams 23a o	al D	1820 Spence Sti	eet #221				212	30						ulir
ams	iner	11. Marital Status	12. Was Deced	ent Ever in U	J.S. 13.	Was Dece	dent of H	ispanic Or	igin? (Spec	cify Yes or No-	1	14. Race - A Black, W		
5-0036 72 hours after natural; or its	Y FL	1 Never Married 2 Marrie	ed 1 ☐ Yes 2 If Yes, Give	™ No	1	1 ☐ Yes		Specify		,		Specify:	whi	
5-0036 72 hours at natural; or digal Example	ed b	3 ☐ Widowed 4 ☑ Divorced 15. Decedent	Year or Dat	es:	16a Dece	dent's Usua	al Occup	ation				nd of Busine		
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Maryland d 2 should be fill th and Mental H it is marked out	10	19a. Informant's Name/Relationsh Robert Stebbing			1					Route Number more, N	-		e, Zip C	Code)
C = 54 F		20a. Method of Disposition	5/111end	20b.	Place of Dispe	osition (Nar	ne of	T	Daili			21230 cation - City	or Tow	n State
nore		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (Sp	3 □Removal from St	ate	cemetery, cre	matory`or o	ther plac	(e)			200. 40.	action only	0. 10.	ii, otato
Baltimore, sermi. Pages 1 ar Department of Hea mportient: if item in yinjury or otha		21 Consture of Euparal Carrier I	inanana	011	2	2. Name ar	d Addres	ss of Facili	ty1	655 W.	D - 1			· · · · · · · · · · · · · · · · · · ·
Depariment of the police of th		Ronald S	Wade D	y solo	/	tate A		_		633 W.	ват	timor	2 50	reet
		23a. Part1. Enter the disease, or shock or heart failure. List of	complications that car	used the dear	th. Do not en	ter the mod	le of dyin	g, such as	cardiac or	respiratory arr	est,		1	Approximate nterval Between
Physician		Immediate Cause (Final disease or condition			CUTE	R	EN	n	F	21/11/0	£		,	Poset and Death
/Medical		resulting in death)	Due to (o	as a consec	quence of):			-	, ,	nlur 15				FIUNCES
- Cxammer		Sequentially list conditions,	b	as a consec	RH.	A-BI	DI	nyo	LYS	15			1	DAYS
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C43 to (c	as a consec	paerine ory:									
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Vision of Vital Records, P.O. Box 68766 Attanding Physician: The law requires that the death certificate be redeath. sctor: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregn h 2 □ Feta		DEctopic pr	egnancy				2	3d. Date of	- ,	
O. E. Ine dea	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of o	death 5[Other (sp	ecity)					Month	D	ay Year
P.O. that the deed by the detached	Phy	Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the u	inderlyina c	alica dive	en in Part I		23e Did tol	hacen us	e contribute	to the	cause of death?
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Division of Vital Records, to Attanding Physician: The law requires taller cleath. Diractor: After this certificate has been signed in by the funeral director, page 2 should be of	Certification:	2 Accident investig	ation			М		Yes 2□						
Division or Attance after death Diractor: in by the	rtifi	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Place 0	f Injury - At h , etc. <i>(Speci</i> i	ome, farm, sti fy)	reet, factory	, office		28	If. Location (St City or Town	reet and n, State)	Number or	Rural F	Route Number,
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To the within 2 To tha complex	Me	29b. Signature and title of certified				290	. License	number		2	9d. Date	signed (Mo	nth, Da	y, Year)
		4	Usin	DR			PIE	3619	3		Ju	NE.	1.	2005
_		30. Name and address of person w	no completed cause	of death (Iter	n 23a) (Type,								, /	w
			BRIN, S		GNES		SALT	MCA	RE,	BALT	mD	RE.		
C+	ate	31. Date filed (Month, Day, Year)	2005 3 Rec	istrar's Sign	re de									

			•	For State Registrar	tate of Marylar	_	artment of F			gierie () () Reg. No.	5	975	6
		Physicia		Decedent's Name (First, Middle, Last)				NDEEN.	2. Date of Dea	Day	Year	3. Time of Dea	-
		/Medic	al	SAM		LIAM		GREEN or Location of Deat	June	4c. County	of Death	22:51	4M
		Examin	er	4a. Facility Name (If not institution, give stre	2 of Da	1 Bus	40. City, 10W	altima	e City	, de. county		N/A	,
3		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h y, Year)		ice (State or Fo	reign
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کے		the Marylar 28a-f show	Director	MD BALTIMO	KE	BALI	I MORE	-		10g. Citizen of W	Vhat Count		*
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		death	Funeral	11 Marital Status 12.	Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puer	specify Yes or No	14. Race	e - America k, White, e		
Villi	98	or ite	by Fu	1 ☐ Never Married 2 💢 Married	1 X Yes 2 □ No If Yes, Give	1	1 ☐ Yes 2 💢 No		,,	Specify		whITE	
3	5-0036	hours tural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educati	Year or Dates:	16a. Dece	dent's Usual Occur	pation		16b. Kind of Bu			
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non	Maryland	2 should be filed within 72 hours afti and Mental Hygiens Is marked other than "natural; or laumatic event, Ite Medical Evention	မှ	HYMAN 19a. Informant's Name/Relationship (Type,	Print)			and Number or R	ural Route Numbe	er, City or Town,			
3	N N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Interportant: if item 27 is marked other than "natural," or items 23a or 28a-f show arry injury or other traumatic event, it a Medical Evaninal must be notified at once.		CHARLOTTE GREEN /	WIFE	6529	COPPERF	IELD ROAD	- BALTI	MORE, M	D 212	09	
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÷	Bal	permij Depar Impo any ir		21. Signature Funeral Service Licensee	THE STATE OF THE S		2. Name and Addre	TERSTOWN	L LEVINS				3
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		Physician		shock, or heart failure. List only one of Immediate Cause (Final disease or condition	O ((do ex	100	bouse	R				Onset and Dear	
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	Вох 68	death certificate b attending physi of for use as the b	Physiclan/Med	IF FEMALE: 23c.	If yes, outcome of pregr	nancv				23d Dat	e of deliver	v	
	Bo	death of attented for u.	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fel 4 ☐ Pregnant at time of	tal death 3 (□Ectopic pregnand □ Other (specify) _	y		Moi		Day Year	r
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	o u	ling P	on:	atural 5 1 oriding	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ıryat ork?]Yes 2.⊟No	28d. Describe	how injury occurr	ad		
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		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (ian: To the best of my kr :: On the basis of examinand manner stated.								
		To th within To th compl	Me	29b. Signature and title of certifier				se number		29d. Date signed			
		~) july , M	. 0.		182	ES - 00	6	June 9	1 200	5	
		12		30. Name and address of person who comp				L of	BALTIM	0 1 5			
		Sta	ate	31. Date filed (Month, Day, Year)	3 Registrar's Sign	nature	ltose i na	- 31	ソコレ()か	- 14-5			
		Regist		JUN 1 4 2005	Sieve ,	D. A.	are						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Holmes Month Day Year 36 PM 2005 Jun 11 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death General Hospital Howard County Howard Olumbia If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🗶 F JULY 16, 216-207633 1922 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2313 N. DUKELAND STREET 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MILLINERY COAT FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDIE D. FITZGERALD CORDELIA LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAGERTHA M. SELLERS/DAUGHTER 815 HOPEWOOD ROAD BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ST.MATTHEW CH. CEM. MEHERRIN, VA 6-18-05 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final embolism pul monary 4 hrs disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

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Completed

Be

10a. State

MD

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examinat

Baltimore. Maryland 21215-0036

the Maryland

With

death

Examiner as the burial-transit Physician/Medical

and the attending physician hed for use as the buria use detached þ 2 been signe should be has Be ٩ this s after death.

I Director: After this of in by the funeral d Certification:

The law requires that the death certificate be executed

Hospital or Attending Physician:

24 hours

To the Within 2 To the

Division of Vital Records, P.O. Box 68760

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify) _

NIA

23d. Date of delivery Month Day

1 Yes 2 No 3 Probably 4 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabeter Chronic

6 Could not be

determined

renal arteru

Failure

24a. Was an autopsy perform 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

Year

Loconary 25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work? 2 🗌 No 1 Tes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

М

29d. Date signed (Month, Day, Year) Tune 11, 2005

29b. Signature and title of certifier

Harry

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10780 Hickory Ridge Rd,

Columbia,

mD21044

State Registrar

31. Date filed (Month, Day, Year) JUN 1 4 2005

Li,



DHMH 17 Rev 1/2001

M.D.

State of Maryland / Department of Health and Mental Hygien@ () For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year George C. Hankey IUNE 03 2005 :30 AM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES HOSPITAL BALTIMORE n/a if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Months NOKM 2□F Director Yrs. 219-38-4306 25, 80 1925 Maryland lan. Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at ō XXYes 2 □ No 28e-f MDBaltimore Catonsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 815 Winters Lane Apt. 405 21228 **TISA** Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel". Any injury or other traumatic event. Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give Year or Dates: Never Married 2 Married þ 1 Yes & No Specify: white white Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy W. Hankey 2 Annie Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Edmondson Ave. Baltimore, Maryland 21229 <u> Melvia Hagan- Guardian</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State ' 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery | 6 - 9 . 700\$ Baltimore City 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MAryland 21229 Mangel 23a. Part. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician theumonia disease or condition resulting in death) 15 DAYS /Medical Due to (or as a consequence of): Examiner VA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical esn esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ GlomerulonepHRITIS NECROTIZING 3 ☐ Probably 4 Munknown funeral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 XNatural 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0002500 ewy-Jun 03 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue BATIMORE, MO HUSPITAL 900 CATION St Agnes NGOUMONTA TIENNE 31. Date filed (Month Day, 1 4 2005 32. Begistrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland .		artment <i>tificate</i>			and M	lental Hy	/gien	4 U U	5	19759
			1. Decedent's Name (First, Middle, La	st)							2. Date of D Month		1011	V	3. Time of Death
	Physici /Medic			Caroline	Theres	sa Ho	lt				June	10,	2005	Year	12:40 P M
	Examir		4a. Facility Name (If not institution, giv	e street and number))		4b. City, T	own, or	Location of	of Death		4	c. County o	f Death	
			6213 Roblynn Roa	đ			Laure	el					Princ	e Ge	orge
	Funeral		Social Security Number 6. S	ex 7. Ag ☐ M 2 [X](F	ge (In yrs. last		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	rth ay, Yea	r) i	Cou	plece (State or Foreign ntry)
	Director		1/2-26-5431		71	Yrs.					Dec 9	, 19	33	Penr	nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation								10d. Inside City Limits
	Maryi f sho	5	MD Prince	Seorge	Laur	2									1 ☐ Yes 2 ☐ No
	the 28a	rec	10e. Street and Number	deorge	Haui	CI	10f. Zip (Code				10g. C	itizen of W	hat Cou	71
	3a or	Ö	6213 Roblynn Road	Ē			207	707				_	S.A.		,
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show his Madical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Vas Decede	nt of His	panic Orig	gin? (Spe	cify Yes or N	0-	14. Race	- Amen	can Indian,
9	or Ite	Fur	1 ☐ Never Married 2 🔀 Married	Armed Forces?			Yes, speci	_		, Puerto	Rican, etc.)			, White,	etc.
03	ral', c	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1953-5	7	I□Yes 2	No No	Specify:				Specify:	Whi	te
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest gra	ducation de completed)	1	6a. Deced	lent's Usual kind of work	Occupa	tion urina most	of worki	na		Kind of Bus		•
21	ithin ne.	idu	Elementary/Secondary (0-12)	College (1-4or		life. L	DO NOT use	retired)					nited		tes
	fed w fygier her ti		12 17. Father's Name (First, Middle, Last,			Admir	nistra					-	overnn		
and	be fi	Be	Peter B. Skiba								(First, Middle Brozy		n Sumame)	
Ĕ	hould d Mei mark matic	2	19a. Informant's Name/Relationship (Tuna Brintl		10h Mailin	- Address ((Ctroot o			i Route Numb		T 2	M-1- 7:	0.41
Maryland	d 2 s Ith an 17 is t			spouse							rel, M				,
	Heal Heal tem 2		20a. Method of Disposition		20b. Place	e of Dispos	sition (Name	e of			ate	- 4	Location - C		
JU OF	ages ant of nt: If i		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif				natory`or ott 's Cem	•	·	uno	15, 05	Lai	ırol	Max	v1and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treumatic event, the Madical Examiner must be notified at ance.		21. Signature of Funeral Service Licer	-	150.	22	Name and	Addrage	of Eacility						
ä	permil Depar Impor any ir		A Solvittan	IL.	M00773	Do	onalds 13 Tal	on I bott	Tuner Ave	al H . La	ome, Pure1,	.A. Mary	land	207	07
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	d the death. [Approximate Interval Between
M	Physician		Immediate Cause (Final)		atic S										Onset and Death 6 months
	/Medical		resulting in death)		a consequen		CETT	Бапс	Can	CCI					o monens
	Examiner		Sequentially list conditions,	b											
	pe iii	dicai Examiner	il any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	Ce UI).									
2	cate be executed physician and the burial-transit	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to /or as	a consequen	co of\:								-	
68760,	be exician buria	aiE		Due 10 (01 a3	a consequent	Ce OI).									
387		dic		d											
_	certif iding ise as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	,							23d. Date	of delive	201
Box	death certific e attending p ed for use as	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pre						Mont		Day Year
P.O.	0 4 2	Physician/M	9 Unknown	9□ Unknown											
	es that gned b	by P	Part II. Other significant conditions of	ontributing to death b	out not resultin	ig in the un	iderlying cai	ıse giver	n in Part I.		23e. Did	tobacco	use contrib	ute to th	ne cause of death?
Records,	The law requires that the ate has been signed by th bage 2 should be detache	edk	Chronic Obstruct:	ve Lung D	isease						1 📉	Yes 2	2 □ No 3	☐ Prob	ably 4 Unknown
000	s bec	piet									24a. Was	an	24b. We	ere auto	psy findings available
Ä	The lav	Completed									auto perfo	omed?	de	ath?	mpletion of cause of
Vital	10 -	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only				
of V	Physicien: this certificated director,	2	1 ☐ Yes 2 XNo	Hospital: 1 🗀 Inpatie	ent 2 ER/	Outpatien	3 □ DOA	Other	4 🗀 Nu	sing Hon	ne 5 ⊠ Resi	dence	6 Other	(Specif	y)
		.uo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28	b. Time of Injury	28	c. Injury	at	2	8d. Describe	how inj	ury occurred	d	
sio	tend leath lor: the	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 🗆 N	-					
Division	l or Attendater death Diractor:	Certification;	4 Homicide determined	286. Place of Inj	c. (Specify)	, farm, stre	et, factory,	office		2	City or To			or Hura	I Route Number,
J			29a. Certifier 1X Certifying Ph	ysician: To the best	of my knowley	doe death	Occurred at	the time	data and	t place a	and due to the	221122/	a) and man		Inted
	24 h	Medical	(Check only 2 Medical Examone)	niner: On the basis o	f examination	and/or inv	estigation, i	n my opi	nion, deat	h occurre	ed at the time,	date ar	nd place, an	d due to	the cause(s)
	To the Hospitel or At within 24 hours after or To the Funerel Diract completely filled in by	Me	29b. Signature and title of certifier				29c.	License	number			29d. D.	ate signed (Month,	Day, Year)
	V		11.8	2			D2	5422	?			Jun	ie 13,	200)5
	007		30. Name and address of person who	completed cause of c	leath (Item 23	a) (Type, F	Print)								
	0		Robert Maggin, M.		Balti			Laur	el,	Mary	land 20	0707			
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2	005 32 Negistr	ar's Signature	do	de								
	a Georgia	al .	コロル エ エ に	AARTONAA											

DHMH 17 Rev 1/2001

			1- For State Registrar State of Maryland / Department of Heat Certificate of Department of Department of Heat Certificate of Heat Certificate of Heat C	alth and Mental Hy	•	19760
			1. Decedent's Name (First, Middle, Last)	2. Date of D	eath Year	3. Time of Death
	Physici /Media			JUNE	09 2005	4.25 AM
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		4c. County of Dea	ith
				11stown		more County
	Funeral		Months Days	Hours Min. 8. Date of Bi	irth 9. Bi	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	0ct. 1	4, 1903 Ken	tucky
	land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	f sho	ō	Maryland N/A Baltimore			X⊠Yes 2 No
	the 28a	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	3a or		The Wesley Home, Inc. 2211 W. Rogers Avenue	21209	USA	
	ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa	anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.)		
9	or Ite	Ē	Armed Forces? If Yes, specify Cuban, N 1 □ Never Married 2 □ Married 1 □ Yes 2/□XNo If Yes, Give 1 □ Yes 2/□XNo			
933	irel',	d by	3XXWidowed 4 □ Divorced If Yes, Give 1 □ Yes XXNo S		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show I a Modical Exemirer must be motified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupatio (Specify only highest grade completed) (Give kind of work done durit life. DO NOT use retired)	n ing most of working	16b. Kind of Busines:	s/Industry
121	within ne. hen	mp	Elementary/Secondary (0-12) College (1-4or 5+) Antique's Deal		Colf Empl	arrand
	Hygie Hygie Ther t			B. Mother's Name (First, Middle	Self Empl	oyeeu
ano	ad be	To Be	James Smith Hunt	Verda LaVell		
Maryland	d Me mark matic	F	19a. Informant's Name/Relationship (<i>Type, Print</i>) Daughter 19b. Mailing Address (<i>Street and</i>			Zin Code I
Ma	d 2 s th an t7 ls trau		Barbara Ann Hoffman Field 2313 Lighthouse			810
	Heal Heal tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City o	Town, State
υOπ	ages ent of nt: If i		XXBurial 2 □Cremation 3 □Removal from State '4 □Donation 5 □Other (Specify) XBurial 2 □Crematory or other place) St. Louis Cemetery	6/14/2005	Henderson.	Kentucky
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinet must be notified at once.					
B	permi Depa Impo any i		Bur ee-Henss	of Facility s-Seitz Funera Koad Baltimor	1 Home, Inc	• 21211
	10000		23a. k. rt1. Enter the dije se, or complication, that caused the death. Do not enter the mode of dying, s shock, or heart failur. List only one c. une on each line.	such as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Fin	Neches		Onset and Death
	/Medical		Due to (or as a consequence of):	21261126		
85	Examiner		Sequentially list conditions, if any, reading to immediate b. Due to (or as a consequence of):	ferretion.		
	ъ <u>щ</u>	ner	Sequentially list conditions, if any, leading to timilediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.			
	and and I-trans	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):			
60,	death certificate be executed e attending physician and od for use as the burial-transit	cal E	Sub-to-to-to-to-to-to-to-to-to-to-to-to-to-			
68760,	phys phys the					
×	certif Iding	/We	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	liven
Вох	death certifica attending ph for use as t	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		Month	Day Year
P.O.	the cachec	Physician/Med	9 Unknown			
	The law requires that the der ate has been signed by the a page 2 should be detached fo	by P		in Part I. 23e. Did	tobacco use contribute t	o the cause of death?
rg	w require been sig should b	edt		1 🗆	Yes 2□No 3□P	robably 4 Munknown
Records,	aw requast been 2 should	plet		24a. Was	s an 24b. Were a	utopsy findings available
H	The ate har page	Completed		perf	ormed? death? 2 X No 1 ☐ Ye	completion of cause of
Vital	sertifica ctor,	Be (25. Was case referred to medical	6. Place of Death (Check only		
of V	Physicien: r this certificated firector,	户	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	4 Nursing Home 5 Res		ecify)
n	ding Physicien: The lav h. After this certificate has funeral director, page 2	on:	27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		how injury occurred	
Sio	Attending or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	s 2 No	(Street and Number or C	tural Cauta Alumba
Division	or A after Direction by	Certification;	4 Homicide 4 Homicide 4 Still Homicide 5 Still Homicide 4 Still Homicide 5 Still Homicide 4 Still Homicide 5 Still Homicide 5 Still Homicide 6 Still Homicide 6 Still Homicide 6 Still Homicide 6 Still Homicide 6 Still Homicide 6 Still Homicide 6 Still Homicide 6 Still Homicide 7 Still Homicide 8 Still Homicide 8 Still Homicide 8 Still Homicide 8 Still Homicide 8 Still Homicide 9 Stil	City or To	(Street and Number or R own, State)	urar noute ryumber,
	politel			date and place, and due to the	cause(s) and manner a	s stated
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinione)	ion, death occurred at the time	, date and place, and du	e to the cause(s)
	To the within To the complex c	Me			29d. Date signed (Man	th, Day, Year)
	/		> gogmon P Meltam.D Dy	410	June 09h	,2005
/	101		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	IDER P MEHT	A	
F		le:	HORTHWEST HOSPITAL CENTER RANDALLS	STOWN MO	21133.	
	Sta		31. Date filed (Month, Day, Year) 1 4 2005 Registrar's Signature			
	Regist	rar	JOH I I LOUS JURIOUS DE PARTIE			

Œ		1- State of Maryland / D		artment rtificate			and M		giene Reg. No	. 000	19761
Physic	ian	1. Decedent's Name <i>(First, Middle, Last)</i> Russell 1. Bite						Date of De Month	ath Day	y Year	3. Time of Death
/Med Exami		4a. Fecility Name (If not institution, give street and number)		4b. City, T	own, or	Location of	of Death	June	4c.	2005 County of Dea	1240 0
LAdilli	nei	Charlestown Care Center		-		svil			F	Baltim	ore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	thday) Yrs.	If Under Months		If Under :		8. Date of Bir (Month, Da			rthplace (State or Foreign ountry)
Director		577-07-0700 1	113.					9/22,	/191	9 Was	hington D.C.
uyland show	_	10a. State 10b. County 10c. City, Town	n or Lo	cation							10d. Inside City Limits
he Ma 18a-1 s	ecto	MD Baltimore	Ca	tonsvi					10 01		1 ☐ Yes 2 No
Sa or	Dir	707 Maiden Choice Lane Apt. 3120)	10f. Zip		21228	1			izen of What C S . A .	ountry?
death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		Was Decede				cify Yes or No Rican, etc.)		14. Race - Am Black, Whi	
s after	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	ĺ	1 ☐ Yes 2	4	Specify:	, , , , , , , , , , , , , , , , , , , ,	incarry once,		Specify:	White
ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28a-f show event, the Mcdrell Examiner must be notified at		15. Decedent's Education 16a.	Dece	dent's Usual	Occupa	ıtion			16b. K	ind of Business	
thin 7. If the Part of the Par	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of worl DO NOT use		luring most)	t of workii	ng	_		
1 21 lied wi tygien thar th		17. Father's Name (First, Middle, Last)	Acc	counta	nt	18 Mothe	r's Namo	(First, Middle,		lic Uti	lity
ed al be	To Be	Russell H. Hite				Ruth		-	, ivialderi	Sumame)	
and and sum	-	19a. Informant's Name/Relationship (Type, Print) 19b.	. Mailir	ng Address	(Street a	ind Numbe	r or Rura	I Route Numbe	er, City o	r Town, State,	Zip Code)
								Apt {		Catons	ville, MD
0 0		1 ■ Burial 2 □ Cremation 3 □ Removal from State cemeter				- 1					
Baltimo permit. Pag Department Important: I any injury o		' 4 □ Donation 5 □ Other (Specify) Cedar I 21. Signature of Fineral Service Licensee	22	L Ceme	eter Addres	y 6 s of Facility	/8/2 Wit	005 zke Fur	Sui	tland,	MD of Catons-
		Deman Delmestei	v	ille 1	1630	Edmo	ndso	n AVe.	CAto	onsvill	e, MD 21228
		23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence or condition resulting in death)		e 9	130	803	Ø.				Years
Examiner			017.								
D 118	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):								
xecute and	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):						-		
ox 68760, ~certificate be executed riding physician and use as the burial-transit	dical E	d									
c 68 antifica ing phy		IF FEMALE:							-		
or the agh	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death		Ectopic pre Other (spe						23d. Date of de Month	olivery Day Year
. 0 00	hysic	1 Yes 2 No 9 Unknown	3	J Other (spe	(City)						
ecords, P.O. law requires that the de as been signed by the a 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in	the u	nderlying ca	use give	n in Part I.					o the cause of death?
ecords, taw requires t as been signe	eted							-	Yes 2		robably 4 Unknown
- 0 C 0	Completed							24a. Was autor perfo	an osy irmed?	24b. Were a prior to death?	utopsy findings available completion of cause of
VITAL	O)	25. Was case referred to medical				26. Place	of Death	1 ☐ Yes (Check only o	2 Z No	1 Yes	s 20 No
- 8 Si B	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	tpatien	t 3 🗆 DO/	Othe					6 □Other (Spe	ecify)
E 5 9		1 Natural 5 □ Pending (Month, Day Year) II	Time of njury	28 M	C. Injury Work	at ? ∕es 2 □ i		8d. Describe I	how injur	y occurred	
DIVISION I or Attending after death. Diractor: After tin by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	rm, str			63 2 1					ural Route Number,
DIN tall or is after all Dira	Certification:	4 Homicide determined building, etc. (Specify)						City or Tov	vn, State)	
DIVISION To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At	edical	29a. Certifier Certifying Physicien: To the best of my knowledge (Check only one) Medicel Exeminer: On the basis of examination and manner stated.	death dor in	n occurred a vestigation,	t the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c.	License	number			29d. Dat	e signed (Mon	th, Day, Year)
1		Tyle mla				989			Ju	nec	H 2005
V		30. Name add address of person who completed cause of death (Item 23a) (Туре,				· i -	1 -		tonsi	
SI	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	IN		S1)	CD	DICE		C.a.	10051	11112
Regis		JUN 1 4 2005	084	W.							

			For State Registrar	State of Maryland	•		ntal Hygien	1e2 0 0 5	19762
			Registrar 1. Decedent's Name (First, Middle, I	ast)	Certificate of		Reg. N	lo.	3. Time of Death
	Physicia /Medic		Eva. M	Hanre				y Year	- 1/20 P M
	Examin		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, o	r Location of Death		c. County of Dea	th
	E		7430 School 5. Social Security Number 6.	Sex 7. Age (In yrs. last	DUV (de t birthday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	Balti 9. Bir	HORE thplace (State or Foreign
	Funeral Director		215-82-3094	10 M 20 F 44	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Yea 27/14	160 9	Taky land
	iand bw		Usual Residence of Decedent 10a. State 10b. County	10c. City (1	Nown or Location				10d. Inside City Limits
	ith the Marylan or 28a-f show se notified at	ctor	MD Bal	HIMORE]	bundalk				1 ☐ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number	11	10f. Zip Code	1220	10g. (Citizen of What Co	ountry?
	ms 234	eral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	1222 lispanic Origin? (Specif	y Yes or No-	14. Race - Ame	
9	or Ita	y Fur	1 Never Married 2 Married	If Yes, Give	If Yes, specify Cuba		an, etc.)	Black, Whit	te, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Mcdital Examinal must be notified at	ed by	3 ∰Widowed 4 □ Divorced 15. Decedent's	Year or Dates:	16a. Decedent's Usual Occup	-	16b.	Kind of Business	/Industry
215	thin 72 e. en "ne	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of working d)		22	11
	be filed with Ital Hygiene Id othar tha evant, the	Cor	17. Father's Name (First, Middle, La	stl	Hom	18. Mother's Name (F	Eirst Middle Maide	OWN	Nome
land	ould be f Mental I arkad o' atic eva	То Ве	Robert	J Pick	e-tt	Cathe	RINE	E S	nith
Maryland	2 should I and Meni Is marka		19a, Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street		loute Number, City	or Town, State,	Zip Code)
	1 and 2 Health tam 27	}	20a. Method of Disposition	20b. Plac	e of Disposition (Name of	Date	1/een 20c.	Location - City or	Town, State
OE I	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	Hemoval from State	etery, crematory or other place	bell 6/13	105-3	Hunes	ms
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural, or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at one.		21. Signature of Funeral Service Lic	rensee	22. Name and Addre		FULLER	al Han	ne DA
	0 □ = e o		23a. Part1. Enter the disease, or co	emplications that caused the death.	2134 2	1, 170W S	Spiratory arrest.	2d., 21	Approximate
	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each line.	2R HOSIS	•			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen					J / LARS
Ü		er	Sequentially list conditions, if any, leading to immediate	b. HEPATIT. Due to (or as a consequent					5 YEARS
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C					
8760,	ate be executed hysician and the burial-transit	ical Ex	resulting in death) Last	Due to (or as a consequen	nce of):				
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	edica		d					
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	ath 3 Ectopic pregnancy	(23d. Date of de	livery Day Year
P.O.	the deg	ysic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	h 5 ☐ Other (s <i>pecify</i>) _			14131111	July Vou
	res that the designed by the a	by Pr	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause giv	en in Part I.			the cause of death?
ord	w require been sig should b						remarkens p	4	robably 4 Unknown
Records,	ne faw e has b ge 2 si	Completed					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	ysician: The Is certificate hadirector, page	Be Co	25. Was case referred to medical			26. Place of Death (C	1 ☐ Yes 2X N Check only one)	√o 1 ☐ Yes	2 □ No
of V	Physician: r this certifica ral director, i	2	examiner? 1 Tyes 2 No		VOutpatient 3 □ DOA Oth	4 Nursing Home			cify)
lon	atte fine	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Bb. Time of 28c. Injur Wor 1 □	yat 200 k? Yes 2 □No	d. Describe how inj	july occurred	
Division	r Attanditer death iractor: A	Certification;	3 Suicide 6 Could not determine		e, farm, street, factory, office	28f	. Location (Street a City or Town, Sta		ural Route Number,
	Hospital or 14 hours afte Funaral Dira tely filled in I	I Cel	29a, Certifier (X Certifying	Physician: To the best of my knowle	adde, death occurred at the tir	ne date and place and	due to the caused	(s) and manner as	estated
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Ex	aminer: On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurred	at the time, date a	nd place, and due	to the cause(s)
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier	man Ole ma	29c. Licens			Date signed (Mont	
			Vhiles (fall	varello,	. 1000	36643	4	0/10/0.	5
7			30. Name and address of person wh	o completed cause of death (Item 2					
_	45			LECLA, MD 9105	3a) (Type, Print) FRANKLIN	SQUARE	DRIVE,	BALTIM	no re
	Sta Registr	_		LECLA, MD 9105	3a) (Type, Print) FRANKLIN	SQUARE	DRIVE,	BALTIM	no RE

			1 - For State Registrar	State of Maryland / Depa	artment of Healt		ntal Hygien	4000	19763
	Physici /Medi Examir	al	Decedent's Name (First, Middle, Last) AR HM 4a. Facility Name (If not institution, give s		PR 4b. City, Town, or Local		6 8	Year 2005	3. Time of Death 12:45 ★ M
	Funeral Director	lei	FRANKLIN SQUARE H 5. Social Security Number 217-05-2162 6. Sex		ROSEDA	nder 24 Hrs. 8.	Date of Birth (Month, Day, Yea	BACTIMOR 9. Birtho	lace (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23s or 28e-f show any injury or other traumatic event, the Medical Exercited from the notified at Once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD BalhM 10e. Street and Number 2/26 W. //ow 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Hassy Hass F 19a. Informant's Name/Relationship (Typ. 20a. Method of Disposition 1 Burial 2 Gremation 3 Relationship (Typ. 20a. Method of Disposition 1 Burial 2 Gremation 3 Relationship (Typ. 20a. Method of Disposition 1 County Property) 21. Signature of Funeral Service Ricense	2. Was Decedent-Ever in U.S. Armed Forces? 1. Priss 2 No If Yes, Give Year or Dates: /444 -/445 ation College (1-4or 5+) FINE 2. Was Decedent-Ever in U.S. 13. 144 1445 16a. Deced (Give Infe. In	Nas Decedent of Hispania f Yes, specify Cuban, Mer I Yes 2 No Specific Coupation kind of work done during to NOT use retired 18. Mer I R.	c Origin? (Specifixican, Puerto Rice acity: most of working MG INCLA Mother's Name (F	10g. Covernos de la companio del companio del companio de la companio del companio	itizen of What Coun U.S. A. 14. Race - America Black, White, e Specify: W. Kind of Business/Ind U.R. H. The Sumame)	an Indian, etc. All He dustry Code)
8760,	Certificate be executed his price as the bursel rears it is as the bursel rears it.	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	er the mode of dying, such	h as cardiac or re	spiratory arrest,	Qd. 212	Approximate Interval Between Onset and Death
P.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions conf	nbuting to death but not resulting in the un	derlying cause given in Pa	art I.		use contribute to the	e cause of death?
Vital Reco	The law ate has b page 2 sh	e Completed	25. Was case referred to medical		ne D		24a. Was an autopsy performed?	prior to com death?	sy findings available indiction of cause of
Division of Vi	ding Phy After this funeral d	Certification; To Be	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	aspital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2	28d. 2 □ No	5 Residence Describe how inju		
Div	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.		4 Homicide determined 29a. Certifier 1X Certifying Physi	28e. Place of Injury - At home, farm, stre building, etc. (Specily) cien: To the best of my knowledge, death er: On the basis of examination and/or inv	occurred at the time, date	e and place, and	City or Town, Stat	c) and manner as eta	tod
)	To the P within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.	29c. License numb	per	29d. Da	a place, and due to the signed (Month, D	
か	7	-	30. Name and address of person who con	ppleted cause of death (Item 23a) (Type, F	Print)				2
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 200	9000 FRANKLIN S 36 Registrar's Signature	de de	- , STU	in topic ,	110 2123,	r

		1	For State	State of Maryland		artment of Health and M rtificate of Death	lental Hygien	Six U U U	19764
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia	an	SUNILYNN 1	10NYAI H	ENRY	(ay Year 2005	1.10 PM
	/Medic Examin	- 4	4a. Facility Name (If not institution, give s	1919		4b. City, Town, or Location of Death		c. County of Deat	7 1 1 1 1 1 1 1 1
		7	GREATER BALTIMO	RE MEDICAL	CTR	TOWSON		BALTIMO	
	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yee		hplace (State or Foreign untry)
D	irector	-	NONE Usual Residence of Decedent			25	JUNE 7,200	75	- FID
land	Mon		10a. State 10b. County	10c. City	, Town or Lo	ocation			10d. Inside City Limits
Man	is 1-a ithed	ctor	MD	13	ALTIM	10RE			1 Yes 2 No
th the	or 28	Oire	10e. Street and Number	D Ac-	2	10f. Zip Code	10g. C	itizen of What Co	ountry?
athw	238 mat c	rail	1275 KITMOR		0	21239	acifu Vac or No	14. Race - Ame	nican Indian
er de	Itam	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
urs aft	o le	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No Specify:		Specify: BL	ACK
5 Pg 7	ical E	ted	15. Decedent's Educ (Specify only highest grade	cation	(Give	dent's Usual Occupation kind of work done during most of work	ing 16b.	Kind of Business/	Industry
thin 7	Men "	Completed	Efementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		NEANT	•
G Z IZ ID-UUDO filed within 72 hours atter death with the Maryland	Intrysions and statural', or itams 23s or 28s-f show other than medical Exaction must be notitled at		17. Father's Name (First, Middle, Last)		كمن ا	NFANT	e (First, Middle, Maide		
d be fill	Department or health and whenlar hyperical important; or items 23s or 28s-1 show important; it item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at another.	To Be	MICHAEL	HEN	RY	ROXAN	VE	WRIG	GHT
shou	umat umat		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Maili	ng Address (Street and Number or Rur	al Route Number, City	or Town, State, 2	Zip Code)
, Ma	n 27 i	,	GBMC. PATHOL	26/	6701	N. CHRLESST	Tourson 1	W. Z12	204
es -	or ne If Item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	_	lace of Dispo emetery, crei	osition (Name of matory or other place)	Date 20c.	Location - City or	Town, State
ITIMO	tant: I		* 4 ☐ Donation 5 ☐ Other (Specify)	(512		buni (remarch 6191	2005	7470, GI	17, 114.
Dall Permit	Important in once.		21. Signature of Funeral Service License	10	22	2. Name and Address of Facility	500y (o.	M.	
			23a. Pert1. Enter the disease, or compli	cations that caused the deat	h. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
O _b	ysician		shock, or heart failure. List only or Immediate Cause (Final	RESPIRA	TORY	DISTRESS			Onset and Death
N ST	nedical i	li L	disease or condition resulting in death)	Due to (or as a conseq		DIOTRES			
Ex	aminer		Sequentially list conditions,)	Valuation (See				
p _e	sit	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	wanca orp				
xecut	sician and burial-transit	Examiner		Due to (or as a conseq	uence of):				
, P.O. Box 68/60, that the death certificate be executed	hysician a the burial	icai E		J					
tificat	ig phy as th	fedi	10.000.000						
BOX Bath cert	attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, out <i>co</i> me of pregna 1 ☐ Live birth 2 ☐ Feta	death 3	☐Ectopic pregnancy		23d. Date of de Month	livery Day Year
ь ф В	by the at tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	leath 5	Other (specify)			
Pat th	d by detack		Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	o the cause of death?
ds,	signed b d be det	d by	Tutti.		•	, , , ,	1 ☐ Yes	2 No 3 P	robably 4 Unknown
Records, The law requires t	been signal	Completed					24a. Was an	24b. Were a	utopsy findings available completion of cause of
E E	cate has to page 2 s	E C					autopsy performed 1 ☐ Yes 2 🖼	death?	
ta E	certificate rector, pay	0	25. Was case referred to medical			26. Place of Dea	th (Check only one)	10 10	2,53.110
yaich S		To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Other: 4□ Nursing H	ome 5 Residence	6 ☐Other (Spe	ecify)
Vision of Vita	h. After this funeral di		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of fnjury (Month, Day Yeer)	28b. Time o	Work?	28d. Describe how in	jury occurred	
SiO	er death. •ctor: After by the fune	catie	2 Accident investigation 3 Suicide 6 Could not be	an Division to the		M 1 Tyes 2 No	28f. Location (Street	and Number or P	ural Pouto Number
÷ 5	after deatl Director: I in by the	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, rarm, si fy)	reet, factory, office	City or Town, St		urar noute reuniber,
	hours ineral y filled		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, dea	th occurred at the time, date and place ovestigation, in my opinion, death occu	, and due to the cause	(s) and manner a	s stated.
o the Hospital	within 24 hours affe To the Funeral Dir completely filled in	fedical	one)	and manner stated.	and and of I			Date signed (Mont	
P°	To con	Σ	29b. Signature and title of certifier	/1		29c. Lidense number	7	17/15	, 009, 1841/
			20 News of the Wally	ompleted cause of death (the	m 23al /Tuca	Print) A A		1/103	1 1
			30. Name and address of person who o	ompleted cause of death (Iter	610	19 M. Charless	M. Vo	upper	14) 21704
	St	ate	31. Date(filed (Month, Day, Year)	32. Registrar's Sign	ature				
	Regist	rar	6-9-05 JUN	1 4 2005		4 /			

ORIGINAL

DHMH 17 Rev 1/2001

			1 - State of I		artment of Health a rtificate of Death		giene Reg. No. 0 0 5	19765
	Physici	ian	Decedent's Name (First, Middle, Last)	T		2. Date of Dea Month	ath Day Ye	3. Time of Death
	/Medi	cal	Marie 4a. Facility Name (If not institution, give street and numb	Jame		6	7 2005	1:20 p M
	Examir	ner	Future Care N.H.	<i>ai)</i>	4b. City, Town, or Location of Lochearn	Death	4c. County of D	timore
	Funeral Director		224–36–1950 ¹□M ¾ F	Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birt (Month, Da	th 9. 12-26	Birthplace (State or Foreign Country) PA
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	the Marylar 28e-f show notified at	ō	MD NA	Baltimo				XXYes 2 □ No
	r 28e	rec	10e. Street and Number	Dartimo	10f. Zip Code		10g. Citizen of What	Country?
	th wit	a D	2809 Woodland Ave		21215		U.S.A	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, tre Modical Exartirer rust be notified at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced 12. Was Decede Armed Force 1 Yes X If Yes, Give Year or Date	s? No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race - A Black, W Specify:	merican Indian, /hite, etc. Black
15-	"net	ete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most (DO NOT use retired)	of working	16b. Kind of Busine	ss/Industry
12	within iene. then	Completed	Elementary/Secondary (0-12) College (1-40	or 5+)	PN		Numaina	Home
b	other ent, I	BeC	10th grade na 17. Father's Name (First, Middle, Last)			's Name (First, Middle,	Nursing Maiden Sumame)	nollie
/lar	should be ind Mental marked o umatic eve	To B	Oscar Blow		Lizzi	ie McCoy		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, Ire M.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number	or Rural Route Numbe	er, City or Town, State	e, Zip Code)
	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tru once.		Frances Smith-Daughte		West Garris			
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Dispo cemetery, crer	natory or other place)	Date	20c. Location - City	or Town, State
ij	it. Pa irtmer irtent: njury		' 4 Donation 5 Other (Specify)					ills, Md
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee	٠	Name and Address of Facility March F.H. Wes		more, Md. Wabash Ave	21215
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not ent	er the mode of dying, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Congo St	we though I	Failure		Onset and Death
	/Medical Examiner		resulting in death)	as a consequence of):		(31.6.0		
	Lxammer	-	Sequentially list conditions, b.	as a consequence of):	124			
	ned	nine	cause. Enter Underlying Cause (Disease or injury	as a consequence of).	-			
Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events	as a consequence of):				
8760,	ysicia ysicia	dicai	d					
9	ng ph as th	Medi	IF FEMALE:					
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of o Month	delivery Day Year
S, P	The law requires that the tee been signed by the base been signed by the bage 2 should be detache	by P	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	w require been sign		Kenal insure and	3 icy		1 □ Y	'es 2 → 3 □	Probably 4 Unknown
ecc	e taw r has be je 2 sh	Completed		0		24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
<u>=</u>		Con				_ perfor	med? death 2 Dlo 1 ☐ Y	es 2 L
Vital	ysicien: This certificate director, pag	Be	25. Was case referred to medical examiner?		0.1	of Death (Check only or		
of	S D	P.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of Ir			sing Home 5 Resid		oecify)
	ding Ph h. After th funeral	tion	1 atural 5 Pending (Month, I	njury 28b. Time of Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		ow injury occurred	
Division	Attendil r death. ector: A by the fu	fica	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, str			itreet and Number or	Rural Route Number,
ā	s after of Direct	Certification:		etc. (Specify)	,,	City or Tow	m, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the be 2 Medicel Examiner: On the basis and framer	of examination and/or inv	occurred at the time, date and vestigation, in my opinion, death	place, and due to the coccurred at the time, d	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	o the	Me	29b. Sgnayure and title of certifier ()	C.A	29c. License pumber	A 3	29d. Date signed (Mo	nth, Day Tear)
			\$1 \$ 10 cm X 6	AL	7320	104	2010	00
	0		30. Name and address of person who completed cause o	f death (Item 23a) (Type,	Print)			l .
	0		Mc neal Brocking	on	Kandale	Stork	md	21133
	Sta Registr		31. Date filed (Mooth Pay, Year) 2005 3 Red	strar's Signature	ales			

t Johnson _{For} 1- State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 5
t Johnson _{For}	State of Maryland / Department of Health and Mental Hygiene
8833	rease Type of Thirtin black indenbie link. Litsuic All copies Are Legible.

KOI	pert Jo		SONFor 1 - State Registrar	Otate of IVI	aryland / De C	ertificate o		na Mentai	Rag. N	1005	197	66
П			Decedent's Name (First, Middle, Last)					of Death		3. Time of	f Death
	Physici		Robert Je	erome		Johnson	Tr	June		2005	1019	, M
	/Medio		4a. Facility Name (If not institution, give				or Location of			lc. County of Death		A
	Exami		5905 Gwynn Oak Av	70m110		Woodlay	7973			n-1+:		
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthda	(v) If Under 1 Year	r If Under 2	4 Hrs. 8. Date	of Birth	Baltimore	nplace (State ountry)	or Foreign
ш	Director		216-74-5789	M 2□F	35 Yrs.	Months Day	s Hours	Min. (Mon.	16	69	MD	
	pu 💉		Usual Residence of Decedent		100 City Town	1					101111111	
	shov	_	10a. State 10b. County		10c. City, Town or	Location					10d. Inside C	
	8e-f	Funeral Director	MD NA		Baltin							2 No
	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. (Citizen of What Cou	untry?	
	23e	ral	5905 Gwynn Oak	Ave			1207			U.S.A		
	e de me	nu	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	 Was Decedent of If Yes, specify Cu 	Hispanic Orig ban, Mexican,	in? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Amer Black, White		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other then "naturef", or Items 23e or 28e-f show other treumatic event, ite Medical Examiner mail he notified at	by Fi	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2.7 If Yes, Give X Year or Dates:	No	1□Yes XXN	o Specify:			Specify: B	lack	
ŏ	2 ho	Completed	15. Decedent's Edu	cation	16a. De	cedent's Usual Occ	upation		16b.	Kind of Business/I		
75	within 7. ene. then "n	pie	(Specify only highest grad	(e com <i>pleted)</i> College (1-4or	(Gi	ve kind of work dor DO NOT use reti	e during most red)	of working				
7	d with	E		na na		hotogra	nher		Ph	oto Unl	imita	đ
Þ	e filed I Hygli other	Be C	12th grade 17. Father's Name (First, Middle, Last)	11.0		11000910	18. Mother	's Name (First, N	liddle, Maide	en Sumame)		-1
Maryland	ould be Mental Marked c	To B	Robert J. Johns	son Sr.			Reiko	o Aso				
ary	and Menistrements and Menistrements and Menistrements and Menistrements and Menistrements and and and and and and and and and and		19a. Informant's Name/Relationship (T	(pe, Print)	19b. Ma	ailing Address (Stre			Vumber, City	or Town, State, Z.	ip Code)	
	1 and 2 Health a lem 27 Is		Reiko McCowan-N	lother	402	8 Boarn	an Av	o. Balt	imor	bM .o	21215	
re	ges 1 at of He ff Item or other		20a. Method of Disposition			B Boarn sposition (Name of rematory or other p	lace)	Date	20c,	Location - City or 1		
E	Pages nent of I ont: if Ite		Burial 2 Cremation 3 6	Removal from State		s Memor		6/11/05	5 A	rbutus,	Md	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens			22. Name and Add			= -			
ä	Der Per		Kinetti	K. In		larch F/	H West	t ve. Bal	timo	re. Md	2121	5
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not					Ley Ma	Approximat Interval Bet	
			shock, or heart failure. List only o Immediate Cause (Final	Acc O	ne	Ctal.	~ A	. Hi	1170	. 01	Onset and	ween Death
	Physician / /Medical		disease or condition resulting in death)	a. Mull	a consequence of):	Stall	mal	cum	100	mas		
	Examiner			Due to (or as	a constituence or).			,				
	166	e_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	à consequence of).							
V	unsit	in I	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
~	af-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							
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89	tificate ig phys as the	Medical		u.								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of deliv	/erv	
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<u>α</u>	# pap		Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause	given in Part I.	23e.	Did tobacco	use contribute to	the cause of c	death?
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	10		30. Name and address of person who c	ompleted cause of	leath (Item 23a) (Typ		~					
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Registrar DHMH 17 Rev 1/2001

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	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
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a l	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.
	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Specify:	White
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	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	during most of wo d)	orking		,
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Nelli	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, i	Maiden Sumame)	
	To	John Joseph Keat				Joan M			
omer treumants		19a. Informant's Name/Relationship (7			ing Address (Street				te, Zip Code)
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и	Physicia		Sok	Kon Kim		2006 1	2005	820 P M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	1
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	shor	2	M N	Toc. only, rown	O Location		'	10d. Inside City Limits 1 Xes 2 □ No
	the N	ect	10e. Street and Number		HLTI MORE	1.40-		
	with a or	ä	4018 254 5	+ 12 100	10f. Zip Code	10g. (Citizen of What Cour	ntry?
	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or itams 23a or 28a-f show evant, the Medical Examinational be mutilised at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	necify Yes or No-	14. Race - Americ	can Indian
(0	r itar		1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	If Yes, specify Cuban, Mexican, Puert	Rican, etc.)	Black, White,	
21215-0036	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes → No Specify:		Specify: Ko	rean.
5	72 hc natur	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work	ting.	Kind of Business/In	
7	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	All g	7 - 4	4
	filed with Hygiene ither tha	S	12.		JUNER .	K	ESTAU.	RANT
P .	be fi	Be	17. Father's Name (First, Middle, Last)	W .	18. Mother's Nar	ne (First, Middle, Maid	en Sumame)	
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Maryland	12 sh h and 7 is m traum		19a Informant's ame/Relationship (Ty	ре, Print) 19b.	. Mailing Address (Street and Num or Ru	ral Route Number, City	y or Town, State, Zip	Code)
_	is 1 and 2 should by Health and Men itam 27 is marks other traumatic		20a. Method of Disposition	20b. Place of	Disposition (Name of	Date 20c.	Location - City or To	101) [10 42
<u>0</u>	Pages nent of int: If its iry or o		Burial 2 ☐ Cremation 3 ☐ F	Removal from State & cemeter	ry, crematory or other place)		11:	
Baltimore,		i	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	4 Ciline		19-05	inon.	m // 63
B	permit. Departr Imports eny inj		King (Q. Q.)	20 Just 4 10	DEALERON NITERALD	WES FUN	COAL	MMD 21093
			23a. Part1. Enter the disease, or compl	ications that caused the death. Do r	not enter the mode of dying, such as cardiac	or respiratory arrest,	aute . le	Approximate
	Physician		shock, or heart failure. List only of					Interval Between Onset and Death
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of V	8 9 =	10	1 ☐ Yes 2X No	lospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specif	y)
n o		e :	27. Manner of Death 1 Natural 5 ☐ Pending		Time of 28c. Injury at mjury Work?	28d. Describe how in	jury occurred	
sio	tan leal lor the	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Division	or Attand after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street: City or Town, Sta		al Route Number,
	Hospital		29a. Certifier 1X Certifying Phy	pician: To the best of my knowledge	a, death occurred at the time, date and place		(-) I	
	a Hos 24 hc a Fun etely	dical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	d/or investigation, in my opinion, death occu	red at the time, date a	(s) and manner as si ind place, and due to	tated. the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
/			DBLOC. 1	N, D,	ump1875 2	J.	une 11	2005
8) (30. Name and address of person who co	impleted cause of death (Item 23a) ((Type, Print)	0 1	, , ,	00.0
	Sta	te	Chanda Bell, 31. Date filed (Month, Day, Year)	MD 201 Eu	ump 1875 2 (Type, Print) (S+ University Park)	way Bal-	imore,	, IN(I)
	Registr	-	JUN 1 4 201	32 Registrar's Signature	Cooli			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 918AM amb 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 HILJORR C If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 F Yrs. 215-44-03/0 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ns 23a or 28a-f shov must be notified at 1 Yes 2 No Director timore 10W5ON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 305 20 Funerai 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. erthan "natural", or Itams the Wedical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 The Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WKIHL þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: if itam 27 is marked other than ury or other traumatic avant, the M Automotive mechanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN SO DHA ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terrapin Terrace 512 MD 21085 Daughter 01 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State view Creyator 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility, Ford Ly - 1 Sk to N 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or *spiratory frest, sporting of the complication of the complete Course (The complete Course (The course of the course Home FUNERAL Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aryngeal Avker Physician DEN S /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed 1 ☐ Yes 2 🖂 No Vital Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ot this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: within 24 hours after death. To tha Funeral Diractor: After Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 JUNO 12 2005 28303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST Battone no wo 6601 AMON Charles 31. Date filed (Month, L

Registrar DHMH 17 Rev 1/2001

State

22. Registrar's Signature

1 4 2005

			For	• •	aryland / Dep		Health and	Mental Hyg		19770
			Stete Registrer Decedent's Name (First, Middle, Last	*5	Ce	erinicate of	Deam	2. Date of Dea	ith	3. Time of Death
	Physici	an	MILDRED	/		KOLODNY		JUNE 9		3:00 P M
	/Medic		4a. Facility Name (If not institution, give	street and number)			or Location of Dea		4c. County of Death	
	Examin	ıer	MANOR CARE NURSI			40. Oxy, 10mi, 0	TOWSON			TIMORE
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthda)	/) If Under 1 Year	If Under 24 Hr			place (State or Foreign
	Director			□M 21/0 F	88 Yrs.	Months Days	Hours Mir	8. Date of Birth	5° 1917 Cou	MI
	D.		Usual Residence of Decedent							
	rylan	_	10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
	Ba-fa	cto	MD BALTIN	10RE	GLE	N ARM				1 ☐ Yes 2 🕅 No
	iff th	by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	
	23a	la l	12112 HOOPER LAN	NE			21057			USA
	r dez	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White	
36	or the	Ϋ́F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 🐧 i If Yes, Give	40	1☐ Yes 2💢 No	Specify:		Specify:	WHITE
21215-0036	within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28a-f show ta Medicul Eraini ar rinal be rotified at		15. Decedent's Edu	Year or Dates:	162 Dog	adont's Heuri Ossu	nation		16b. Kind of Business/lr	adveter.
5	"na"	Completed	(Specify only highest grad	de completed)	(Giv	edent's Usual Occu re kind of work done DO NOT use retire	during most of wo	orking	100. Killa di Basillessyli	idustry
2	withi ene. than	m d	Elementary/Secondary (0-12)	College (1-4or 5		ISTERED N			MEDICINE	
	filed Hygir Sther		17. Father's Name (First, Middle, Last)	•	1			me (First, Middle,	Maiden Sumame)	
an	ould be filed Mental Hygid arked other atic event, t	To Be	HERFORD		FISK	E	BERTH	Α	SAI	NBORN
Maryland	s 1 and 2 should be filed within 72 hours efter death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show litem 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Erain are trivial for collified at	F	19a. Informant's Name/Relationship (T)	уре, Print)	19b. Ma	iling Address (Street	t and Number or F	Rural Route Numbe	r, City or Town, State, Zi	p Code)
\leq	and 2 : ealth ar n 27 is		DOUGLAS KOLODNY-H	IRSCH / SO)N 330	6 LEE COU	IRT - BAL	TIMORE, N	MD 21208	
5	permit, Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once.		20a. Method of Disposition		20b. Place of Dis			Date	20c. Location - City or T	own, State
9	Pages nent of int: if it		1 X Burial 2 □ Cremation 3 □! `4 □ Donation 5 □ Other (Specify,		1	N CHIZUK		12/2005	BALTIMORI	F. MD
Baltimore,	permit, Pages Department of Important: If If any injury or once.		21. Si navire Funeral Service Licen	1//	the second secon	22. Name and Addre			SON & BROS.	
Ba	permit. Departr imports any inje		MAINININ	Lune			3		PIKESVILLE,	
	_		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused						Approximate
			Immediate Cause (Final	one take on each li	ne.			- 4		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. MCT	a consequence of):	-12 12	MEW	10/4		
н	Examiner			Due to (or as	a consequence or,					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):					
	uted d ansit	min	Cause (Disease or injury							
Ć,	sician and burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence of):					
760,	The law requires that the death certificate be executed ate be assected the last been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		d.						
68	ifficat g phy as th									
Box	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnanc			23d. Date of deliv	very
m	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		Other (specify)	;y 		Month	Day Year
P.O.	t the	Physician/Med	9 🗆 Unknown	9□ Unknown						
	s tha	by P	Part II. Other significant conditions co	_ \	11		ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b	ed t	ICCUR	RENI	URIA	while I	MACE	1 🗆 Y	es 2⊒No 3∏Pro	bably 4 Unknown
Records,	aw requ s been s should	olet		INFEC	EN DE			24a. Was a	an 24b. Were aut	opsy findings available ompletion of cause of
Be	The ta	Completed						autop perfor 1 Yes	med? death?	No No
Vital	ysician: The lavis certificate has director, page 2	BeC	25. Was case referred to medical				26. Place of De	eath (Check only or		*
>	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2☐ No	Hospital:	ent 2 ER/Outpati	ent 3 DOA Ot	her: Nursing	Home 5 Resid	ence 6 Other (Speci	ify)
o	ding Phys	ë	27. Manner of Death	28a. Date of Inju	ry 28b. Time		iry at	28d. Describe h	ow injury occurred	
ion	ndin ath. r: Aft e fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y rear) injury		Yes 2 No			
Division	Atte or dea ecto by th	Hic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or Run	ral Route Number,
	s effe	Cert		building, or	0. (0,000.1)			J., 5. 75.	.,	
	To the Hospital or Attending Phwithin 24 hours eiter death. To the Funeral Director: Atter th completely filled in by the funeral	Medical Certification:							cause(s) and manner as	
	he H in 24 he Fi plete	edic	one)	and manner st	ated.					
	To t To t	Σ	29b. Signature and title of certifier	11 -			se number	2	29d. Date signed (Month)	, Day, Year)
	~/		Cladent	Derro)	12C	3450		6-10-05	
	5		30. Name and address of person who d	ompleted cause of o	leath (Item 23a) (Typ	e, Print)		,	7.0	
٥	L		WARRENTE	PNER	1220 E.	1089A R	0 2	1286		
		ate	31. Date filed (Month, Day, Year)	32. Registr	12-20 E. ar's Signature	1.1.				
	Regist	rar	JUN 1 4 20	105 Acres	IN ST. A	positi				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 2:05 P 2005 Breece (nmn) Leftridge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE SQUARE Kose dale If Under 1 Year | If Under 24 Hrs. 405 RAUKIN 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours **№** M 2 F Months Yrs. Director 1930 Maryland Jan. <u> 220–22–4401</u> Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or items 23a or 28a f show treumatic event, the Medical Examinar mast be notified at 1 ☐ Yes 2X No Director Maryland Baltimore <u>Nottingham</u> the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 **USA** 8518 Westerman Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2 □ No Yes, Give Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: Specify: þ 3√2 Widowed 4 □ Divorced Year or Dates: USA Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7/ ih and Mental Hygiene. 7 Is marked other then "n Residential & Elementary/Secondary (0-12) College (1-4or 5+) 9 Commercial Construction General Contractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clara Leftridge, Sr. Hazel Reedy William Denton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 8518 B Westerman Circle, Nottingham, MD 21236.
e of Disposition (Name of Date 200. Location - City or Town, State other Theresa Kissinger - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department Importent: If any injury or 20029. 6/14/05 Baker's Cem. Aberdeen, Maryland 21. Signature of Fundal Service Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only orle cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. End STAGE TOTER ST'

Due to (or as a masequence of): Preumonilis /Medical **Examiner** Sepsis NIEROCOCCUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Asbeslosis Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 2 No 1 Yes 1 Yes Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 5 Hospitai within 24 hours a filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centiler com ted cause of d th (Item 23a) (Type, Print) of perso

State Registrar

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31. Date filed (Month, Day, Year)

DR. KAMIUN Augeung

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ORIGINAL

19/9000 FRANKlin SquARE DR. BAITIMORE Md 21237

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7th, 2005 4:00 A June Robert Van Mapp /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12504 Indian Hill Drive Sykesville Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□F 77 Director 228-24-1035 13, 1927 Virginia Nov. Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d Inside City Limits 28a-1 show 1 Yes 2 No Sykesville Howard Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12504 Indian Hill Dr. 21278 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 📆 Marned Baltimore, Maryland 21215-0036 ŏ 1□ Yes 💥 No Specitwhite Specify: white er than "natural", o 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than in traumatic event, the Mental county, t Efementary/Secondary (0-12) College (1-4or 5+) Vice Chairman Distributer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Mapp 2 Annie Retta Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 12504 Indian Hill Dr. Sykesville, Maryland 21278
e of Disposition (Name of Date 20c. Location - City or Town, State Betty Lou Mapp- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State Crestlawn Cemetery June 11,05 Marriottsville, MD *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home Baltimore, Md 21229 3620 Wilkens Ave. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** It at; resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-t Due to (or as a consequence of) Box 68760, physicien Completed by Physician/Medical as the attending p IF FEMALE: 23c. ff yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ↑ ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No death Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 - Homicide 29a, Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and Atle of certifier 29d. Date signed (Month, Day, Year) 29c. License number 4113 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 4 2005 Registrar

			For State Registrar		epartment of Health and Mertificate of Death	lental Hygien	(800 19770
	Physicia	an	Decedent's Name (First, Middle, Last)	ΔΛ :		2. Date of Death	ay Year 3. Time of Death
	/Medic	al	Mary A	.	4b. City, Town, or Location of Death	JUNE 1	c. County of Death
	Examin	er	4a. Facility Name (If not institution, give stre	et and number)	Ti out out). (1) M	-	PALTI MORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	2 VF GG Yrs).	(Mogth, Day, Yea	O MARYLAND
	yland now		10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
	Be-f si	Director	MD BALTIN	LORE TI	movium		1 □ Yes 2 No
	with the or 2		10e. Street and Number	Valla Rd	10f. Zip Code	10g. C	Citizen of What Country?
	death	Funeral	d 300 Dolaney 11. Marital Status	Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
98	hours after death with the Maryland tural', or Items 23e or 28e-f show at Examiner must be multified at	y Fur	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 Yes 2 No Specify:	Hican, etc.)	Black, White, etc.
21215-0036	tural,	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's Educal	Year or Dates:	ecedent's Usual Occupation	16b.	Kind of Business/Industry
215	within 72 ene. then "nat	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) (C	Give kind of work done during most of work fe. DO NOT use retired)	ing	11 0 =
	filed with Hygiene. sther thei		17. Father's Name (First, Middle, Last)	150	cretary	e (First, Middle, Maide	alto. Co. lax.
Maryland	d tal	To Be	Thomas Cova	heir	Mary	Fllen B	adu
ary	2 should and Men Is marke eumatic	-	19a, Informant's Name/Relationship (Type	Print) 19b. N	lailing Address (Street and Number or Rur	al Route Number, City	or Town State, Zip Code)
-	1 and 2 Health em 27 l		M. Ann Maher	20h 9lass of D	L North Way Kd	KIESTCI 20c.	stown MD 2130
altimore	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	oval from State cemetery,	crematory or other place)		Location - City or Town, State
altin	- 5 5 5		' 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee	Dylaney	22. Na rie and Address of Facility	105 11	MONIUM MAZIOGZ
ä	Departiment Depart		Samuely 4. 2	arrothy	PEACEFUL ALTERNATIVE	ES FUNER	ALY CREMATION CIR.
Е	<i>3</i> 5.		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ions that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a prisequence of)			
	Examiner			Due to (of as debrise points of)	DE F MARENT	4	
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	xecute and	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E	L d				
9	artificating physe as th	Medi	IF FEMALE:				
Вох	eath certific attending p	lan/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
O.	by the destached	Physici	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	J Ottler (specify)		
S,	es that igned to be det	by P	Part II. Other significant conditions cont	buting to death but not resulting in th	ne underlying cause given in Part I.		use contribute to the cause of death?
ecords,	w requir been s should		Charetre	20000 Se fa	100313		2. No 3 □ Probably 4 □Unknown
Rec	The law ate has t page 2 s	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital		0	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 2 ☐ N h (Check only one)	lo 1 Yes 2 No
of V	hys his	To B	1 195 2 140		atient 3 DOA Other: 4 Aursing Ho		
	ding Ph h. After th funeral	tlon:	27. Manner of Death Netural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju		28d. Describe how in	ury occurred
Division	Atten r deati sctor: by the	Certification:	a Consider 6 Could not be	28e. Place of Injury - At home, farm			and Number or Rural Route Number,
ā	itel or rs afte el Dir		4 D Homicide	building, etc. (Specily)		City or Town, Sta	(0)
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the lunera	edical			leath occurred at the time, date and place, or investigation, in my opinion, death occur		
	To the within To the comple	Me	29b. Signature and the or certified	lote 1250	29c. License number		pate signed (Month, Day, Year)
	//		110		D 15509	8/	113/05
Ì	01		30. Name and address of person who com EDDIE NAKHUDA, M.D.	222		JM, MD 2109	93
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 200	32. 9 gistrar's Signature	book		

DHMH 17 Rev 1/2001

JUNE 11, 2005

MARY MIX

		•	For State Registrar	State of Ma	aryland /		artment rtificate			and M		giene Reg. No.	005	19774
	Physicia		Decedent's Name (First, Middle,	Last)		in	7 .				2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic	al	HUAIG			///	114		Lanation	4 Dooth	JUNE	12	2005 ounty of Deat	18:05P
	Examin	er	4a. Facility Name (If not institution,	// / '	Uscar	1/1	4b. City, To	own, or i	Location o	of Death	1:1	40.00	N/A	n
	Funeral		5. Social Security Number 6		e (Intyrs. last	birthday)	If Under 1		If Under		8. Date of Birt (Month, Day	h		hplace (State or Foreign
10	Director		228-02-4953	1□M 2XF	80	Yrs.	- Months	Days	Hours	Min.	FEB 19		5 K	hplace (State or Foreign untry) Orea
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	Maryli f sho	ō	Maryland Howa	rd	,,			Co1	umbia	a				1 ☐ Yes 2 No
	the r	Director	10e. Street and Number				10f. Zip C					10g. Citize	n of What Co	untry?
	th with		5209 Lynngate	Road				2104	44			1	USA	
	ams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decede	ent of His fy Cubar	spanic Origin, Mexican	gin? (Spe	ecify Yes or No- Rican, etc.)	- 14.	Race - Ame Black, White	
36	d within 72 hours after death with the Maryland jiens then "natural", or Itams 23a or 28a-f show the Mudical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 ☐ Yes 2 🔯 i If Yes, Give Year or Dates:	No		1□Yes 2	No No	Specify:			S	pecify:	Korean
21215-0036	2 hour	ed t	15. Decedent's	Education	1	6a. Dece	dent's Usual	Occupa	tion		1	16b. Kind	of Business/	Industry
215	within 72 ene. then "nat	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or!	5+)	(Give life.	kind of work DO NOT use	done di retired)	uring mosi	t of worki	ng			
7	filed withi Hygiene. other ther	Son	12			H	omemak						Own	Home
Maryland	ba la ba	m	17. Father's Name (First, Middle, La	ist)					18. Mothe		(First, Middle,		ımame)	
<u> </u>	should nd Mer marke rmarke	2	Un Dong Yoo 19a. Informant's Name/Relationshi	n (Type Print)		19b Maili	na Address ((Street a	nd Numbe		Je Lee		own. State. 2	Zip Code)
S	~ a = E		Kyong Cha From				209 Ly			_	Columb			
6	s 1 and 3 if Health Item 27 other tr	1 8	20a. Method of Disposition		20b. Place	e of Dispo	osition (Name	e of			Date		tion - City or	
E	Pages ment of I ant: If Ito ury or o		1 ☐ Burial 2 🎇 Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			•	emator		1	6/13	3/05	Ba1	timore	, MD
Baltimore,	permit. Pag Department Important: any njury o		21. Signature of Funeral Service/Li	censee							of MD, d Baltir	Inc.		
	20E # 3			régorchik			299 Fr	rede	rick	Road	l Baltir	more,	MD 21	
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	niy one cause on each ii	ne.									Approximate Interval Between Onset and Death
	rnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		4 such		ounc	YCL	NK U	1d	hemo	MAC	9.8	11 days
	Examiner			Due to (or as	e hvel	'A	evry	sus						11 days
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as		ce of):								
	ocuted nd transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
,092	death certificate be executed e attending physician and nd for use as the burial-transit	Ĕ	resulting in death) Last	Due to (or as	a consequen	ice or):								
687	physics the b	dicai	~	d				-						
Box 6	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23	d. Date of del	ivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			⊒Ectopic pred ☐ Other <i>(spe</i>						Month	Day Year
P.0	that the de led by the a detached	Phys	9 Mnknown			-					an- Dida			About of death?
Ś	S 0	by	Part II. Other significent condition Mydwey		out not resultir	ng in the u	inderlying cai	iuse give	n in Paπ I	•		obacco use Yes 2□		o the cause of death?
Ö	w require baan sig should b	etec	Sepsis								24a. Was	20	24h Ware 21	stopsy findings available
Vital Record	The law sete has page 2 a	Completed									autop	rmed2	prior to death?	completion of cause of
a		Ö	25. Was case referred to medical						26. Place	of Deatl	1 Yes	20XNo	1 🗆 Yes	2 No
<u>></u>		O B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 ER	/Outpatie	nt 3 DOA	A Othe			me 5 Resid		Other (Spe	cify)
n of		nc: T	27. Manner of Death 1 Natural 5 Pending	28a. Dan of Inju	iry 28	Bb. Time o	f 28	Bc. Injury Work	at ?		28d. Describe I			
Siol	death. ctor: Al	catic	2 Accident investigation of Could not	t ho			М	1 🗆 Y	/es 2□					
Division	or Attendente efter death Director:	Certification:	4 Homicide determin	286. Place of In	jury - At home tc. <i>(Specify)</i>	e, tarm, st	reet, factory,	office			City or Tov		Number or Hi	ural Route Number,
	spitel ours e nerel		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	dge, deat	h occurred a	it the tim	e, date an	nd place,	and due to the	cause(s) ar	nd manner as	stated.
	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: Attencompletely filled in by the fune	Medicai		xaminer: On the basis of and manner st	f examination									
	To the within To the comp	ž	29b. Signature and title of certifier					_	number				-	h, Day, Year)
	1		1 Your	MD.				KES	- 0	000		JUL	VE 12	2005
	1		AA	VAVAL 6	10M DO	LTM	Print)	H	STRE	扩	BAUTI	ront	, MA	-21287
	Sta Regist	ate '	31. Date filed (Month, Hanney)		rar's Signatur		Carl !			•				
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan		rtment of F			liene 0 0 5	19775
l	Physici /Medic		1. Decedent's Name (First, Middle, Last) Mirie Wo	reish				2. Date of Dear Month		3. Time of Death
	Examin Funeral Director	-	5. Social Security Number 6. Sex	Land Medical C		4b. City, Town, o	If Under 24 Hrs. Hours Min.	_	4c. County of Death Year) 9. Birthy County Penn	place (State or Foreign ntry) Sylvania
	D.	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Are		y, Town or Lo		nton			10d. Inside City Limits 1 ☐ Yes 2 No
10	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If itam 27 is marked other then "natural", or Itams 23a or 28e-f ahow or other traumatic avent. The Medical Exoninar must be notified at	by Funeral Director	10e. Street and Number 1212 Odenton R 11. Marital Status 1 □ Never Married 2 □ Married	oad, Apt. 4 2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 XNo	S. 13. V		lispanic Origin? (Si an, Mexican, Puert		USA 14. Race - Ameri Black, White,	can Indian, etc.
21215-0036	thin 72 hours at e. en *natural', or Med cal Exam	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)	If Yes, Give Year or Dates:	16a. Deced	☐ Yes 2 🔯 No lent's Usual Occup kind of work done OO NOT use retire	pation during most of wor	king	Specify: 16b. Kind of Business/Ir	√hite ndustry
Maryland 21	should be filed within nd Mental Hygiene. marked othar then imatic avent, the Ms	To Be Con	12 17. Father's Name (First, Middle, Last) Jabez Allen		Phys	ical Th			Hospita Maiden Sumame)	1
	s 1 and 2 should I f Health and Ment itam 27 ia marker othar traumatic		19a. Informant's Name/Relationship (Type Aland Markish/ 20a. Method of Disposition	Son 20b. F	523		la Court	Oden	r, City or Town, State, Zij $ ext{ton}$, MD 21 20c. Location - City or T	.113
Baltimore,	permit. Pages: Department of the Important: If its any injury or of once.		1 Burial 2 Acremation 3 Re 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Ticense Edward A Gregor	Met	cro Cre	matory.	Inc. 6/11	1/05 of MD, 1 d Baltimo	Faltimore, Inc. ore, MD 2122	ND
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the deat e cause on each line. Due to r as a conseq	h. Do not ent					Approximate Interval Between Onset and Death
8760,	cate be executed physician and sthe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conseq						
.O. Box 6	death certifi e attending id for use as	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ıldeath 3□	Ectopic pregnanc	у		23d. Date of deliv Month	ery Day Year
Records, P.	The law requires that the ste has been signed by tho bage 2 should be detached.	Ď	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.			bably 4 Unknown
Vital Rec		e Completed	25. Was case referred to medical				26. Place of Dea	24a. Was a autop perfor 1 Yes	sy prior to comed? death? 2 No 1 Yes	opsy findings available ompletion of cause of
o	ng Phys fter this meral dii	tlon: To B	examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Input 28a. D te of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju	,		ence 6 Other (Speci ow injury occurred	fy)
Division	or afte in l	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	fy)			City or Tow		
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical		ician: To the best of my knoter: On the basis of examina and manner stated.			opinion, death occu	irred at the time, o		to the cause(s)
)	74		30. Name and address if person who co	m leted cause of death (Iter	n 23a) (Type,	Print)	8543		June 10,	2005
4	St Regist	ate rar	31. Date filled (Month, Day, Year)	32. Figistrar's Signa	ature	back	ivee!	<u>sa itim</u>	are, MD	((4)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:59pm MEYERS 09 2005 CHARLES HERMAN 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CORRECTIONAL INSTITUTION WASHINGTON HAGERSTOWN MARYLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Days Hours Min. August 4, 1959 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□F MD. 217-76-7166 45 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐XNo Middle River Director MD. Baltimore 10g. Citizen of Whal Country? 10f. Zip Code 10e. Street and Number 21220 USA 4014 Keeners Road death v Funeral 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpet Laborer 12 years nd 2 should be filed alth and Mental Hygid 27 is markad other r traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be iit. Pages 1 and 2 should be artment of Health and Menta ortant: If item 27 is markad Anna Long William Meyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4014 Keeners Road, Middle River, Md. 21220 mother Anna Meyers other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) June Date 13, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ö Bayview Crematory 2005 Baltimore City, MD. injury * 4 □ Donation 5 □ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 permit.
Departr
Imports
eny inji 21. Signalure of Funeral Service Licensee man 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final disease or condition resulting in death) END STAGE Physician LIVER DISEASE /Medical Due to (or as a consequence of): **Examiner** INFECTION HEPATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine -transit resulting in death) Last Due to (or as a consequence of) burial Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the at d be detached fo o. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) \(2 \text{\rm} \) No 24a Was an has 1 ☐ Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) PRISON Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P ō this 28a. Date of Injury (Month, Day Year) 27. Manner of Death
1 Natural
2 □ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the Hospitel or Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOUPSI PHYSICIAN MD 052125 06092005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18601 ROXBURY ROAD HAGERSTOWN MD 21746 ODUNSI OLASUPO

State Registra 31. Date filed (Month, Day, Year) JUN 1 4 2005

32. Registrar's Signature

			For State Registrar	11000				d / Depa		t of H	ealth a	and M	lental Hy		200	5	19777
			1. Decedent's Name	e (First, Middle,	Last)								2. Date of De	ath			3. Time of Death
	Physici		Mary	R.	Nihan								Month O6	Day 1		Year 205	10:50PM
	/Medic Examin		4a. Facility Name (III			number)			4b. City,	Town, or	Location of	of Death			County of		10.701
1	Evditiii	Çı	Gilchr	rist Hos	nice				т	owso	n				Balt	-i mo	ne
	Funeral		5. Social Security N		Sex			st birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h V Year)			place (State or Foreign
	Director		034-03-5	5432	1 □ M 2 💢 F		87	Yrs.	MONTHS	Days	riouis	IVIIII.	April '	12,	1918	MA	
	p ,		Usual Residence of 10a. State	Decedent 10b, County			10c City	Town or Lo	nation							14	0d. Inside City Limits
	shov	_		TOD. County													1 ☐ Yes 2 ☐ No
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	with the	Funeral Director	10e. Street and Nur						10f. Zip						zen of Wh	nat Cour	ntry?
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	er de Item	nue	11. Marital Status	and 20 Marria		Forces?		5. 13.	f Yes, spec	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)			, White,	
36	rs aff	by F	3 ₩idowed		If Yes,	s 2√∫N Give rDates:			1 □ Yes	No D	Specify:				Specify:	Wh.	ite
21215-0036	72 hours after death with the Maryland naturel; or Items 23a or 28e-f show dical Examiner must be notified at	Completed by		15. Decedent's	Education			16a. Dece	dent's Usua	I Occupa	ation			16b. Ki	nd of Busi	iness/In	dustry
15	n n n	ple	(Spec	ify only highest		ed) e (1-4or 5	.)	(Give life.	kind of wor DO NOT us	rk done d e retired	<i>luring</i> mos ')	t of work	ng				
212	d within giene. r than "	E	Elementary/3600	(Idary (0-12)	2			Assis	tant	City	Trea	sure	er	Ci	ty of	Lv	an
	othe vent,	Be C	17. Father's Name ((First, Middle, La	st)						18. Mothe	er's Name	(First, Middle,				
<u>a</u>	ald be fonta rked ric ev	To B	Dennis	Keane							Ma	argar	ret (011:	ins		
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan admental Hygiens. Partner of Health and Mantal Hygiens are admented from 23a or 28e-f show ortant: if item 27 is marked other than "naturel", or tlems 23a or 28e-f show injury or other traumatic event, the Madical Exams or must be notified at injury or other traumatic event, the Madical Exams or must be notified at a.g.		19a. Informant's Na	ame/Relationship	(Type, Print)			19b. Mailie	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	er, City o	r Town, S	tate, Zip	Code)
	1 and 2 Health a lem 27 ls		Maura Ni	han / D	aughter	,		1412	Ma er	s La	ndin	Roa	d; Monk	cton	, MD	211	11
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		20a. Method of Disp				20b. Pla	ace of Dispo	sition (Nan	ne of			Date		cation - C		
Ę	Page nent o nt: #		1 ➡Burial 2 ['4 ĎDonation	☐ Cremation 3 5 ☐ Other (Spe	□Removal fro cify)	om State			-	•		6/15	1/2005	т.	ynn.	MA	
Ħ	spartment sportant: fl sportant: fl sy injury or		21. Signature of Fu				- 200		. Name an								Home, P.A.
ä	Depa Impo any ir								85	21 L	och F		Blvd.				
	65		23a. Part1. Enter th	he disease, or co	omplications th	at caused	the death.	. Do not ent							VDOI19	111	Approximate Interval Between
			Immediate Cause (rt failure. List or (Final	lly one cause c	A A	10. T										Onset and Death
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89	certificat nding phy use as th			_										7.	_		
Вох	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE; 23b. Was decedent	t pregnant	23c. If yes,		of pregnan 2 🔲 Fetal (Testaniana					1	23d. Date	of delive	ary
œ.	death e atten ed for u	icia	in the past 12 1 🗆 Yes 2 🛭	months?	4∐Pr	egnant at	time of dea]Ectopic pr] Other <i>(sp</i>						Monti	h	Day Year
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p	quire nn sig uld b												101	/es 2[100 3	Prob	ably 4 Unknown
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	ician: Th certificate rector, pag	a	25. Was case refer	red to medical							26. Place	of Death	(Check only o	_	5-20 to 1		2010
>	ding Physician: h. After this certifici	To B	examiner? 1 ☐ Yes 2 ☑		Hospital: 1	☐ Inpatie	nt 2 🗆 E	R/Outpatier	it 3□ DC	A Othe			me 5 🗆 Resid		s ther	(Specifi	NOSPICE
			27. Mapner of Deal		28a. Da	ate of Injur fonth, Day	y Voarl	28b. Time o	2	8c. Injury Work			28d. Describe I		100		
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	bour hour unere	al	29a. Certifier (Check only	Certifying	Physician: To	the best of	of my know	vledge, deat	benuoso r	at the tim	ne, date an	d place,	and due to the	cause(s)	and manr	ner as s	tated.
	n 24 he Fu	edical	one)	2 Medical Ex	and m	e basis of anner sta	ted.	on and/or in	vestigation	in my op	oinion, dea	un occurr	ed at the time,	gate and	place, an	ia aue to	the cause(s)
	withi To t	Σ	29b. Signature and	title of certifier	0				290	. License	number	_	ĺ	29d. Dat	e signed ((Month,	Day, Year)
			KAU	ran	lu	8				150	5×27	5	4	マシア	211		<i>UU</i> J
,	1		30. Name and addr	ess of person w			eath (Item	23а) (Туре,	Print)	,	0 :		13:N,	^			7
ľ			AARON	CHAM	rs w	N) (0G01	N. (was	رعلا	77	10-	Nº TO	(m	حـ(ک	9	
(34	Sta	ite	31. Date filed (Mon	th, Day, Year)	32	2. Registra	ar's Signati		7)								
	Regist	ar ·		IIIN 1 4	2005	1	. /	K &	ade								

DHMH 17 Rev 1/2001

6-10-05 C 10:50pm

Nihan, Mary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year OHMSTEDE GEORGE 09 10:55AM JUNE 2005 /Medical 4a. Facility Name (If not institution, give street and number) BRECC 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Raven If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 DM 2 □ F **Director** Mary Ians Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 10 Director BaltiHORE unda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21222 items 23a US A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: WW TT 1□ Yes 2 No þ Specify: White 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Marken in the Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OHMStede WKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code)
27 KINSLIP KOOO, DUNDAIK, MD 2122Z Barbara OHHStebe - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayview Creyatory 113 4 □ Donation 5 □ Other (Specify) 105 22. Name and Address of Facility

Brodley-Ash 21. Signature of Funeral Service Lice FUNERAL HOME, P.A ring Rd. 21222 ton 134 Willow pring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician meumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 No 1 ☐ Yes 2□ No 1 Yes After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Yes 2 No Other: 4M Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred To the Hospital or Attending Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Rate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 056508 SHAO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lock

State Registrar

31. Date filed (Month, Day, Year)
JUN 1 4 2005

2. Registrar's Signature

MD

		•	1 - For State Registrar	State	of Marylan		artment o			lental Hyg	iene ()	05	19779
	Division		1. Decedent's Name (First, Middle, L	ast)						2. Date of Deat Month	h Day	Year	3. Time of Death
П	Physici /Medic			Barba	ra Jean	Przeko	pp			June 12			12:45 a ^M
	Examin		4a. Facility Name (If not institution, go	ve street and nu	mber)		4b. City, Tow	m, or Location	of Death		4c. Count	y of Death	
			Cherry Lane Nur				Laure		04 H		Pri	nce G	
	Funeral			Sex 1 □ M 2 💢 F	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 You Months Da	ear if Under ays Hours	Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent		00					Dec 12,	1938	Wasi	nington, DC
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	Man a-f sh iffed	to	MD Charle	S	Wal	ldorf							1 ☐ Yes 2 ☐ No
	r 28	Director	10e. Street and Number				10f. Zip Cod	de		10	Og. Citizen of	What Cou	ntry?
	th wit		3417 Walnut Cour	t #D			2070	2			U.S.A	•	
	eme erre	Funerai	11. Marital Status	12. Was Dec	edent Ever in U. orces?	.S. 13. \	Was Decedent	of Hispanic C	origin? (Spa	ecity Yes or No- Rican, etc.)		ce - Americack, White,	
36	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28e-f ehow hadical Examiner maat be notified at	by Fu	1 Never Married 2 Married	1 □ Yes If Yes, Gi	ve		1 □ Y <i>e</i> s 2 💆					%White	
Ö	hours turail	g p	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates:	16a Danse	tantla Haval O	tine					
15	n 72 "na"	Completed	15. Decedent's I (Specify only highest g	rade completed)		(Give	dent's Usual Oo kind of work do DO NOT use re	one during mo etired)	ost of work	ing	16b. Kind of I	202111622/11	dustry
7	lene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		ptionis				Healt	n / He	earing
ਰੂ	tilec t Hyg oths	BeC	17. Father's Name (First, Middle, Las	et)				18. Mot	her's Name	e (First, Middle, N	faiden Suma	me)	
Maryland 21215-0036	uld b Menta Irked	ToE	Reginald Hancock					Lil	lian	Cheseldi	lne		
an	2 sho and I is ma		19a. Informant's Name/Relationship	(Type, Print)						al Route Number,	•		
2	and ealth m 27		Victoria Hines /	daughte:						Laurel,			
altimore,	Jes 1 t of H If ite		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3	☐Removal from	State	emetery, cren	sition (Name o natory or other	place)			20c. Location		
<u>=</u>	tmen tent: tent:		`4 □Donation 5 □ Other (Spec		W.					13, 05		n, Ma	ryland
Ba	Depar Impor any ir	10a. State 10b. County 10c. City, Town or Location Waldorf										nd 20	707-4389
Н			23a. Part 1. Enter the disease, or con shock or reart failure. List onl	mplications that of	caused the deatleach line.	h. Do not ent	er the mode of	dying, such a	as cardiac o	or respiratory arre	est,		Approximate Interval Between
	Priysician		tmmediate Cause (Final disease or condition	Meta	astatic	Carcin	noma of	Lung					Onset and Death 1 year
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):							
B	Examine:	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a conseq	neuce of).						-	
	ted nsit	nine	Cause (Disease or injury		(0. 0.0 0.00)	30,100 31,1							
,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
8760,	e be risicia	dicail		d									
9	tificat ig phy as th	ledi											
Вох	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregna	ancv				ate of delive	,
о В	ed for	sicis	in the past 12 months? 1 Yes 2 XNo		nant at time of d		Other (specif)				M	onth	Day Year
<u>Р</u> .	res that the de signed by the a be detached t	Phy	9 Unknown						• 1	22a Did tab		sambusa aa a	he cause of death?
Š	signer bed	by	Part II. Other significant conditions Chronic Obstruct	_				e given in Par	(1.				he cause of death?
0.0	w require been sli should t	etec									т		
3ec	e taw has t	Completed								24a. Was ar autops perform	24b.	were auto prior to co death?	psy findings available mpletion of cause of
a				1						1 ☐ Yes 2	XNo.	1 🗆 Yes	2 No
<u> </u>		o Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:	Innaki 0 [ED/Outpotion	ıt 3□ DOA			n <i>(Check only one</i> me 5 ☐ Reside		has (Casa)	
of	Phys or this oral di	\vdash	27. Manner of Death	28a. Date	of tnjury	ER/Outpatien 28b. Time of		Injury at Work?		me 5 ☐ Reside 28d. Describe ho			y)
lon	Attending or death. ector: After by the fune	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigati		nth, Day Year)	tnjury		Work? 1 ☐ Yes 2 [□No				
Division of Vital Records,	Attendi ar death. ector: A by the fu	iffic	3 ☐ Suicide 6 ☐ Could not determine	d 288. Place	e of Intury - At ho ling, etc. (Specif	ome, farm, str	eet, factory, off	fice		28f. Location (Sti City or Town	reet and Num	ber or Rura	al Route Number,
Õ	rs efte	Certification:		Julia	mig, ote. (open)								
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edicai		eminer: On the b	pasis of examina					and due to the ca ed at the time, da			
	thin 2 of the omple	Med	29b. Signature and title of certifier	and mar	nner stated.		29c. Lic	cense numbe	r	29	d. Date sign	ed (Month,	Day, Year)
	F≥F8		N HI	2	a 0 ' n =	1	D23	181			June 1:		
	10		30. Name and address of person who	o completed cau	se of death (Item	n 23a) (Tvoe							
	10		R. G. Bhojraj, M		4 Gorman			Laurel	, MD	20707			
	Sta	te	31. Date filed (Month, Day, Year)	2005 32.	egistrar's Signa	ature	marks 2						
	Registr	ar	JUN 14	2003	ENEURO J	N A	-						

			For State Registrar	State of Mary		artment of H			ene 0 0 5	19780
	Physici /Medio	cal	1. Decedent's Name (First, Middle, L	m.	Pa	lumb	1	2. Date of Death Month JUNE	Day Year	100 0 100 101 1
	Examir Funeral	er		Medical Ce	enter nyrs. last birthday, Yrs.		TOWSON If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Y		imore hplace (State or Foreign buntry)
	Director works	or	Usual Residence of Decedent 10a, State 10b, County		Dc. City, Town or L	ocation (V 1) i 1/0	,	1vg.24	2,1926 N	10d. Inside City Limits
	ith with the A 23s or 28s-f	al Director	10e. Street and Number G204 Chen	oak ct.	Par	10f. Zip Code	234		. Citizen of What Co	
920	hours after death with the Maryland lurel', or Items 23s or 28e-f show at Examinational be notified at	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:	Fin U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within 72 ane. then "nai	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0·12)		(Give	dent's Usual Occup o kind of work done o DO NOT use retired	during most of working	16	b. Kind of Business	Home
Maryland	should be filed nd Mental Hygie markad othar umetic event, II	To Be C	17. Father's Name (First, Middle, Last William A	Kresskin (Type, Print) Husba	4	ng Address (Street	18. Mother's Name (First, Middle, Ma	taus	nan Zip Code)
-	of Health ard I them 27 is	100	RODE 1 F. 20a. Method of Disposition 1 Description 2 Cremation 3	Palumbi	920 20b. Place of Disp	4 chere	par ct.	Park	c. Locati A - City or	21234
Baltimore	permit. Pages Department of I Importent: If It eny injury or o		' 4 ☐ Donation 5 ☐ Other (Spec	ify)	St. Joseph	os Fullers 2. Name and Address Ron Har	ton 6/17/ ss of Facility Evan: ford rd. (os Lapel	Saltimore	(mi)
	Frrysician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplication that caused the	LEROTIO		g, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death DECADES
8760,	Examiner be executed thysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequatine off:					
P.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of del Month	ivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions Hypertension	contributing to death but n	ot resulting in the c	ındərlying causə gıvı	en in Part I.		cco use contribute to	./
Vital Records,		Completed	Atrial Myxoma					24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of 2 No
f Vit	ys dis	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Anpatient	2 ER/Outpatie	nt 3 DOA Cthe	er: 4 Nursing Home		e 6 □Other (Spe	cify)
Division of	tending leath. tor: After the fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	h 0		of 28c. Injury Work	y at 28 k? Yes 2 □ No	d. Describe how	injury occurred	
Divi	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Diractor: completely filled in by the	al Certifi	4 Homicide determine	building, etc. (Specify) y knowledge, deal	h occurred at the tim	ne, date and place, an	City or Town, S	se(s) and manner as	stated.
)	To the Ho within 24 t To the Fu completely	Medical	(Check only 2 Medical Extended) 29b. Signalure and title of certifier	Iminer: On the basis of exand manner stated	amination and/or ir	29c. License	pinion, death occurred	at the time, date	and place, and due Date signed (Monti	to the cause(s)
1	D.		30. Name and address of person wh	·						
	Sta Registi		31. Date filed (Month, Day, Year)	OO5 Angustrar's	Signature	SLER DRI	VE, TOWS	DN, MA F	RYLAND 2	1204
DH	MH 17 Rev 1/2		JUN 1 4 2	WIS Stewer	-	h				
					ORIGIN	AL				

			For State Registrar		State of M	laryland / Dep <i>Ce</i>	artment of h artificate of			giene Reg. No.	05	19781
			Decedent's Name	e (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death
	Physici		Howard	George	Poteet				June 9.	Day 2005	Year	6:35 A M
	/Medic Examin				e street and number)	4b. City, Town, o	r Location of Death		4c. County	of Death	0.03 11
	Exami		7 Cuyle	r Court			Tows	son		В	altin	nore
	Funeral		5. Social Security N			ge (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	h		ace (State or Foreign try)
ш	Director		234-78-22	18	XXM 2□F	56 Yrs.	litioninis Buys	110010	July 5,			
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or I	ocation				10	Od. Inside City Limits
	Aanyli aho	ō									,	1 ☐ Yes 2 ☐ No
	28a-1	ect	Maryland	Baltimo:	Le	Towsor	10f. Zip Code			10g. Citizen of V	Vhat Coun	tn/2
	with Sa or	٥						004				,.
	death ms 2;	era	11. Marital Status	er Court	12. Was Deceden	Ever in U.S. 13	Was Decedent of H	204 Hispanic Origin? (Sp	pecify Yes or No-		SA e - America	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, If a Medical Exemiter matter notified at	by Funeral Directo		ied 2 Married	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	tNo	If Yes, specify Cuba 1 ☐ Yes 🏋 ☐ No	Specify:	o Rican, etc.)	Specify		
21215-0036	2 hot	ted	/2	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	pation	4.5-	16b. Kind of Bu		ite
218	within 7 ene. than "n	Completed	Elementary/Seco	ify only highest grandary (0-12)	College (1-4or	life	e kind of work done DO NOT use retired	d) auring most or world)	king			
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nd	be fill tal Hy d oth	Be	17. Father's Name (18. Mother's Nam	ne (First, Middle,	Maiden Sumam	e)	
Уa	ould Men Parka	To	George		Cummings					ran		
Maryland	12 should be filed within hand Mental Hygiene. 7 is markad other than "r	1 3	19a. Informant's Na		/ Sister	1	ing Address (Street Creswell			-		Code)
	1 and Healt em 2		20a. Method of Disp		/ 013001	20b. Place of Disc	osition (Name of		Date .	20c. Location -		wn. State
Baltimore,	ages nt of t: If it		1 X Burial 2	Cremation 3	Removal from State	cemetery, cr	ematory or other plac		C 11 0F			
Εï	permit. Pa Departmen Important: any Injury ance:			5 Other (Special			Memorial		The state of the s		ır, M	aryland
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or othar tra once.		> dill	WING.	mar Ro		McComas F				210	00
	a d		23a. Part1. Enter	disease, or con	plications that cause one cause on each	d the death. No not e	1317 Coke ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	210	Approximate Interval Between
	Physician		Immediate Cause (disease or conditio	(Final	A.	Le m	gocardial	Infe	a Lor			Onset and Death
7.	/Medical		resulting in death)	-	a Due to (or a	s a consequence of):	9-20.00					1,
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,	p ii	iner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	nmediate orlying	Due to (or a	s a consequence of):						
	and and I-trans	хагл	that initiated events resulting in death) l	3	c. Due to (or a	s a consequence of):						
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587	ficate phys	edic		•	d							
Box (ath cert	Physician/Mo	IF FEMALE: 23b. Was decedent in the past 12 1 \sum Yes 2 \sum	months?		2 Fetal death 3	□Ectopic pregnancy	Y		23d. Date Mor	e of deliver	ry Day Year
P.0	t the by the	hys	9 ☐ Unknown		9□ Unknown							
	law requires that the de as been signed by the a 2 should be detached f		_		•	but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contr	ibute to the	e cause of death?
rd	w require been sig should b	ed 1	cer	-essul	1945				1 🗆 Y	es 2 No	3 Proba	ably 4 □Unknown
of Vital Records,	law re as be 2 sh	Completed by	hal	povenfla	Non 57.	whome			24a. Was a	sv p	Vere autop	osy findings available
Ä	The law cate has	Com	J.		/				perfor	med? d	leath?	2 2 No
/ita	Physiclan: The this certificate ral director, pag	Be (25. Was case references	red to medical					th (Check only or			
of V	hysic this c	၉	1 □ Yes 2 🔀			ient 2 ER/Outpati		er: 4 ☐ Nursing H)
n	After Unerg	ion:	27. Manner of Deatl	5 Pending	28a. Date of In (Month, D		Wor	rk?	28d. Describe h	ow injury occurre	ed	
Sio	ttend death stor: /	icat	2 ☐ Accident 3 ☐ Suicide	investigatio	e Ogo Pleas of le	njury - At home, farm, s		Yes 2 □No	28f Location /S	Street and Number	or or Rural	Pouto Number
Division	al or A after I Dirac d in by	Certification:	4 Homicide	determined	building, e	tc. (Specify)	rieer, ractory, ornice		City or Tow		or Tibrar	Tioute rumber,
)	To the Hospital or Attending Physiclan: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director.	edicai (29a. Certifier (Check only one)	15€ Certifying Pl 2 Medical Exa	nysician: To the bes miner: On the basis and manner s	t of my knowledge, dea of examination and/or tated.	th occurred at the tin nvestigation, in my o	me, date and place, ppinion, death occur	, and due to the c rred at the time, c	cause(s) and madate and place, a	nner as sta and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and	title of certifier	- Att	endry m	29c. Licens	3 7016	2	29d. Date signed		
	2		30. Name and addr							3 = 14	· mik	1,0021204
	Sta Registi		31. Date filed (Mon	JUN 1 4	2005 32. Regis	trar's Signature	Certi					

				For State Registrar	State of Ma	ırylan		artment of He <i>rtificate of D</i>		lental Hy	gien Reg. N	GUUL	19782
		Physicia	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of De		ay Year	3. Time of Death
		/Medic		Mario Jorge Pera						June 1	0,	2005	9:35 AM M
7		Examin	er	4a. Facility Name (If not institution, g		o Co	* 0	4b. City, Town, or L				c. County of Dea	
4				Gilchrist Center 5. Social Security Number 6.			ast birthday)		owson If Under 24 Hrs.	8. Date of Bi		altimor	
35.4M		Funeral Director		219-52-3310	10 M 2□ F	73	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di 12/08/	ay, Yea.	1 Arge	thplace (State or Foreign ountry) entina
001		D .		Usual Residence of Decedent								1 1119	
0		anylar show	<u>_</u>	10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
6		he Ma	Director	MD Baltimo	re	Tow	son	T					
0		with the		10e. Street and Number	•			10f. Zip Code				itizen of What C	
110/05		leath	eral	1022 Breezewick I	12. Was Decedent E	ver in U.	S. 13.	21286 Was Decedent of Hiso	anic Origin? (So	ecify Yes or N		ted Sta	
19	"	fter d	Funeral	1 Never Married 2 Married	Armed Forces?			Was Decedent of Hisp f Yes, specify Cuban,				Black, Whi	te, etc.
	215-0036	d within 72 hours after death with the Maryland giene. ir then "natural", or Items 23e or 28e-f show the Medical Evaluter investor collited at	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			10 Yes 2□ No	Specify: Arg	entine	5	Specify:	spanic
.0	5-0	72 ho	etec	15. Decedent's (Specify only highest g	Education rade completed)		16a. Deced	dent's Usual Occupation kind of work done dur DD NDT use retired)	on ring most of work	ing		Kind of Business	
Mari	-	within ane. Ihen	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)					Med	dical	
62	42	should be filed within and Mental Hygiene. marked other then matic event, the Mi		17. Father's Name (First, Middle, Las	5+		Pharm		8. Mother's Nam	e (First, Middle	. Maide	an Surname)	
5	and	d be antal ced o	To Be	Gregorio Ramon Pe					Vivina Y				
~	Ž	shoul nd Me mari	Ĕ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street and					Zip Code)
70	Ž	nd 2 alth a 27 is		Norma R. Peralta	/Wife			Breezewic					
2	Je,	s 1 a of Hea Item	1	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place)	1	Date	20c. l	Location - City or	Town, State
Peralta,	altimore,	Page nent ent: If ury or		1 ☐ Burial 2 Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	Hemoval from State ify)		-	ce Cremato	1 1	Jun 11 2005	Bel	tsville,	Maryland
do	Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "sany Injury or other treumatic event, the Megonce.		21. Signature of Funeral Service Lic	ensee A	300 N	86 C	Name and Address remation an	d Funera				
				23a Part1. Enter the disease, or co shock, or heart failure. List on	nplications that caused	the death		717 Green P er the mode of dying,		or respiratory a	Balt arrest,	imore, M	Approximate
		Physician		Immediate Cause (Final	y one cause on each in	9.0	0011	cancer					Interval Between Onset and Death
		/Medical		disease or condition resulting in death)	Due to (or as a	consequ	uence of):	Concer					years
		Examiner		Cognontially list conditions	b								
		D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequ	uence of):						
W		ficate be executed y physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	CORSEGO A	ience of):						
4	68760,	be exicient puria	alE			. 00110041	301100 017.						
	687	ificate g phys as the	edical		d			Pa					
		leath certifi attending I for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						ĺ	23d. Date of de	livery
	Division of Vital Records, P.O. Box	death e atte	hysiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)				Month	Day Year
	0.	w requires that the de been signed by the s should be detached	Phys	9 🗌 Unknown	9□ Unknown								
	ŝ	es this igned be de	by £	Part II. Other significant conditions	contributing to death bu	it not resi	ulting in the u	nderlying cause given	in Part I.				o the cause of death?
	ord	requir een s nould	ted							10	Yes :	2 □ No 3 □ P	robably 4 Unknown
	ec	a law nas b e 2 st	Completed							24a. Was	DSV	prior to	utopsy findings available completion of cause of
	H	: The	Cor							1 ☐ Yes	ormed? 2 2 N		2 □ No
	VIE	Physicien: The law this certificate has brail director, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of Deat				Lacar.
	of	Physic this aral di	 -	1 ☐ Yes 2 ☐ No 27. Manner of D ath	28a. Date of Injur	v	ER/Outpatien 28b. Time of	IL SELDOA	4 Nursing no	ome 5 ☐ Resi 28d. Describe		ury occurred	ocity) NOSPICE
	Ö	nding tth. :: Afte e fune	atlor	Natural 5 ☐ Pending investigati	(Month, Day	Year)	Injury		s 2 🗆 No				
	V.S	Atter	Certification:	3 Suicide 6 Could not determine		ry - At ho	me, farm, str	eet, factory, office		28f. Location (City or To			ural Route Number,
	D	tel or rs afte el Dir	Cer		building, etc	. (0,0001)	,			Ony 0. 70			
		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	29a. Certifier (Check only one) 2 Medical Ex	hysician: To the best of the basis of	examina	wledge, death tion and/or in	n occurred at the time, vestigation, in my opin	, date and place, nion, death occur	and due to the red at the time,	cause(date ar	s) and manner a nd place, and du	s stated. a to the cause(s)
		o the o the omple	Med	29b. Signatore and title of certifier	and manner sta	ieu.		29c. License r				ate signed (Mon	
		F 3 F 8		W W LOW	2 lus			70	7329		0.1	MV 10	2mt
	-	10		30. Name and address of person wh	completed cause of de	eath (Item	23a) (Type,	Print	0-0>		00	10	0 003
		`	1	MARON CU	anles mo	660	XN.	(Marke	is ST	Por Sus	7	MD	4204
		. Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signa							7
1		Registr	ar	JUN 1 4 2005	Storie	D.	Good						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TUNE NTOINE ++ 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SQUARE 6. Sex KOSEC If Under 1 Year BALTIMORE eda HOSPITAL Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F. Months Days Hours Min. Yrs. Director 215-03-4170 MARYL Usual Residence of Deceden 10c. City, Town or Location 10a State 10h County by Funeral Director BALTIMORE TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No. Specify Specify: LUnite. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Square 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be eorg Kazgai ျှ 19a. Informant's N. me/Relationship (Typ., Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trains 000. Date 200. Location - City or Town, State larles Baltimore, 20a. Method of Disposition Date Z 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) DO: DO UNERAL CHAPEL, PSU HARFORD IND 21. Signatur∳ of Funeral Service Licenses 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Emd andiomyopathy **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 □NO 3 □ Probably 4 □Unknown 1 Tyes 24a. Was an

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Records, P.O. Razgoiti Completed Division of Vital Hospital or Attending Physician: 25. Was case reterred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 Inpatient Antoinette 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: After 1 Natural Injury 5 Pending death. 1 ☐ Yes investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 110

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

Approximate Interval Between Onset and Death

Year

1 Yes

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

endma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VITAYEN AIR M.D. 602 SOUTH ATWUUD RC

4 2005 Registrar

29b. Signature and

		State of Maryland / Department of Health and Mental Hygiefie 05 5 5 7 8 1 - For State Registrar Certificate of Death Reg. No.							19784
	Physicia		1. Decedent's Name (First, Middle, Last)	1 Ring	hart	_	2. Date of Death Month ていいと	Day Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	4b. Cit	y, Town, or Location of Deat	1 4	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	Month	ler 1 Year If Under 24 Hrs s Days Hours Min.	(Month, Day,	9. Birth	nplace (State or Foreign
	Director		Usuel Residence of Decedent		Yrs.		2-22	-32 MA	FYCHOL
	Marylan -f show ned st	tor	10a. State 10b. County	10c. City, 1	Por CCI	Hall			10d. Inside City Limits 1 ☐ Yes 2 74No
	with the a or 28a be noti	Director	10e. Street and Number	Aug	10f.	p Code	10	g. Citizen of What Cou	untry?
	r death	Funeral	T. Maria States	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
980	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-f show ha Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1□ Yes	200 Specify:		Specify: W	nite.
Maryland 21215-0036	nin 72 ha n "natu Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's U: (Give kind of I life. DO NOT	work done during most of wo	rking	6b. Kind of Business/I	ndustry
	e filed within at Hygiene. other than '	е Соп	17. Father's Name (First, Middle, Last)	Comogo (· · · · · · · · · · · · · · · · · ·	nomen		me (First, Middle, M	CA NON laiden Sumame)	Q.
	2 should be and Mental la marked o aumatic ave	To B	Gaetano E	nea		Mar	ietta	Annella	
	iges 1 and 2 should be filed within 72 hours atler death with the Marylan It of Health and Mental Hygiene. If itam 27 is marked other than "natural", or litems 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Ty Walter T. Rin	e hart.	4620 K	ass (Street and Number or A	I. BACT	MORE P	10 21.236.
nore	Pages 1		20a. Nethod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	- com	be of Disposition (finetery, crematory of	lame of r other place)	Date 2	20c. Location - City or 1	Fown, State
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service License	30.1	22. Name	and Address of Pacility	TIMORE	1 MD 212	34.
	4		23a. Part 1. Enter the disease or complishock, or heart failure. List only or	cations that caused the death.	Do not enter the m	ode of dying, such as cardia	or respiratory arre	5000 HARF st,	Approximate Interval Between
	rnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequer	CANC	er			Onset and Death
8		<u>.</u>	Sequentially list conditions,						
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):						
8760,	cate be executed physician and the burial-transit	dical Ex	Tosularing in additity East	Due to (or as a consequer	nce or):				
9	leath certifica attending ph I for use as th	/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance				23d. Date of deliv	verv
.О. Вох	at the death by the atte	Physiclan/Me	in the past 12 months? 1 □ Yes 2 NNo 9 □ Unknown	1□Live birth 2□Fetal de 4□Pregnant at time of deat 9□Unknown				Month	Day Year
Δ.	ss tha	by	Part II. Other significant conditions con	stributing to death but not resulti	ng in the underlyin	g cause given in Part I.		acco use contribute to	
Vital Records,	aw require is been sig 2 should b	ompleted					24a. Was an	24b. Were aut	obably 4 Unknown topsy findings available
	The I ate ha page	O						ed? death? No 1 ☐ Yes	ompletion of cause of
of Vit	is dill	To Be	1 1 193 2 30 40		NOutpatient 3	DOA Other: 4 Nursing H	ath (Check only one lome 5 Resider	nce 6 X ther (Spec	hity) Mospice
ion c	Attanding F ir death. actor: After by the funera	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28 (Month, Day Year)	8b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred	
Division	al or Attandir safter death. I Diractor: Af d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical	29a. Certifier Certifying Physics (Check only 2 Medical Examione)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurrent and/or investigati	ed at the time, date and place on, in my opinion, death occu	a, and due to the cau urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Z	29b. Signature and julle of certifier	0	2	29c. License number 0 5 7 3 0 3		d. Date signed (Month	Day, Year)
7	10-1		30. Name and address of person who co	mpleted cause of death (kem 2 S W 660	3a) (Type, Print)	<u> </u>			,
	Sta	te	31. Date filed (Month, Day, Year)	20 Deviated Signatur			VJUN MI	21204	
-85	Registr		JUN 1 4 2	005 Realing	* Sound				

			State of Manuard / Department of Health and		_				
	State of Maryland / Department of Health and Mental Hygiene 0 5 19785								
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Deat	ng. No. 3. Time of Death				
	Physici /Medio Examir		William G. Roesler	Month	Day Year 10 9:15 AM				
			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath O	4c. County of Death				
1	Ladiiii		Bluepoint Niusing and Arhab Douthmore						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr		Year) 9. Birthplace (State or Foreign Country)				
н	Director		213-62-5152 12M 2 F 50 Yrs. Months Days Hours Mir	January 1	1955 Maryland				
	p ,		Usual Residence of Decedent						
	aryla shov	<u>_</u>	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
	he M	Director	MD Baltmore Daltmore						
	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heatih and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examples must be mailfied at	ā	10e. Street and Number		Og. Citizen of What Country?				
		erai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian,				
'	fter d	Fun	Armed Forces? If Yes, specify Cuban Mexican, Pue	rto Rican, etc.)	Black, White, etc.				
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1☐ Yes 2 ☐ No Specify:		Specify: White				
21215-0036	72 ho	Completed by Funeral	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wi	orkina	6b. Kind of Business/Industry				
7	ithin ie.	npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	J. A. I. G. G. G. G. G. G. G. G. G. G. G. G. G.	1				
	filed will Hygien other there and, the	Cor	11 Roufer		CONSTRUCTION				
Ind	ould be filed with Mental Hygiene. arked other than atic event, ILe M	Be		ame (First, Middle, N	faiden Sumame)				
3	2 should be and Mental Is marked c	T _o	Milton Paul Roesler Do	corky	LOPPER				
Maryland	12 sho h and 7 Is mu trauma		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Mumber,	City or Town, State, Zip Code)				
	1 and 2 Health tem 27		20a. Method of Disposition (Name of	Date 2	20c. Location - City or Town, State				
Jo.	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	1.2/.	7 11 ml				
Baltimore,			* 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Sorvice Licensee 22. Name and Address of F cility	13/05	Daltinon, 1111				
Ba	permit. Departr Imports any inju		Dit & Codley-Ashton	Funero	Home, P.A.				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardie shock, or heart failure. List only one cause on each line.	ac or respiratory arre	st, Approximate Interval Between				
, H	Physician		Immediate Cause (Final						
	/Medical		disease or condition resulting in death) a. ENG-STAGE 1+103 Due to (or as a consequence of):						
М	Examiner								
	B 5	ner	Sequentially list conditions, I any, bearing to immediate cause. Enter Underlying Cause (Disease or injury						
	acute and trans	Examiner	triat initiatied events C.						
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687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d						
9 x	ding p	Me	IF FEMALE: 23c. If yes, outcome of pregnancy						
Вох	atten for us	ian	in the past 12 months?		23d. Date of delivery Month Day Year				
P.O.	the de	y Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown						
	es that the de igned by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?				
Records,	quires n sign	d by		1 □ Ye	s 2 No 3 Probably 4 Unknown				
Ö	w require s been si should b	Completed		24a. Was an					
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n of			27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of lnjury at Work?	28d. Describe ho	w injury occurred				
Sio	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	atic	2 Accident investigation M 1 Yes 2 No						
Division	ter direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)				
	urs al eral D								
	Hosp 24 ho Fune fely fi	Medical	29a. Certifier 1	e, and due to the ca curred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)				
	o the thin 2 the omple	Med	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month, Day, Year)				
			5 200		. 1.0/12				
L	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		102 (
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N IS IRM APACLE MID, 25 Main St., Suite 200; Reistarsto WN MD2 113 6 State Registrar 31. Date filed (Month, Day, Year) 12. Registrar's Signature 132. Registrar's Signature									
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	Registr	ar	JUN 1 4. 2005 Render It Goods						

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and M 1 - For State Registrar Certificate of Death		ien e 005	19786	
	Physici	an	1. Decedent's Name (First, Middle, Last) Nancy Rosenthal	2. Date of Deal	Dav Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, give street and number)	June	9, 2005 4c. County of Death	121101 M	
	Examin	ier	University of Maryland Hospital Baltimore		N/A		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day July 27	9. Birth Cor 1937 We	place (State or Foreign intry) St Virginia	
	'and	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	a-fsh		Maryland Anne Arundel Glen Burnie		_	1 ☐ Yes 2 🛣 No	
	be filed within 72 hours after death with the Maryland half Hygiene. All Hygiene. And other than "natural", or items 23s or 28s-f show event, it a Madical Evarities in an inset to institle at all and an analysis.	Directo	10e. Street and Number 10f. Zip Code 21061	1	Og. Citizen of What Cou	intry?	
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto for Yes, Specify Cuban, Puerto for Yes, Specify	ecify Yes or No-	14. Race - Amer	ican Indian,	
တ္		, Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto I Never Married 2 Married I Yes 2 XNo If Yes, Sive 1 Yes 2 No Specify:	Rican, etc.)	Black, White		
2-003e		ed by	3 Widowed 4 ⊠Oivorced Year or Dates:		Specify: Wh		
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2121	ygiene ygiene rer the tt, tre	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) Toll Collector	(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	State of M	aryland ————	
⊆ .	d ta b		17. Fathers Name (First, Middle, Last) Lamos Commor vi 11a	a Childe	,		
/ar			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		. City or Town, State, Z adena, Mary		
	1 and Health Iem 27 Sther tr				20c. Location - City or T		
Baltimore,	permit. Pages Department of Importent: If it any injury or o		1 \(\frac{1}{3}\) Ceremation 3 \(\text{Removal from State} \) 4 \(\text{Donation} \) 5 \(\text{Other (Specify)} \) Cedar Hil Cemetery 6/13/	/2005	Baltimore,	Marvland	
a Ti					eral Servio		
ш			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	ay Balt	imore, Mary	land 21225	
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Myocordial Infance.	. 4	est,	Interval Between Onset and Death	
1			disease or condition resulting in death) a	1100		4	
	Examiner	<u>.</u>	Sequentially list conditions, b. Due to (or as a consequence of):				
	death certificate be executed e attending physician and od for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury				
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9 xo		ed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery	
Ö.	e death he atte ied for		in the past 12 months? 1		Month	Day Year	
<u>о</u>	requires that the de een signed by the a hould be detached t			23e. Did tob	pacco use contribute to	he cause of death?	
rds,	o jo			1 □ Y€	es 2 No 3 Pro	bably 4 Unknown	
S	as b	plet		24a. Was a		opsy findings available ompletion of cause of	
	The ate h page	Completed		perform	ned? death?	2 No	
Vita	Physicien: The r this certificate ha ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 Other: 4 Nursing Hon		e) ince 6 Other (Speci	F.1	
Division of	₽ + <u>B</u>		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		w injury occurred	(9)	
Sior	or Attendati	catlo	2 Accident investigation M 1 Yes 2 No				
N N		Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Rui I, State)	al Houte Number,	
	Hospita 4 hours Funeral ely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	stated. o the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and title of certifier 29c. License number	2:	9d. Date signed (Month,	Day, Year)	
	(NaMous (Unit, 14) DO052950	•	June 9,	300-3	
	K		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Green St. Buttimoe, UTD 2/20	y			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

			1 - State Ragistrar		rtment of Health and Natificate of Death		ene 005	19787
	Physici					June 8,	2005 Year	3. Time of Death 8:40 pm
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street a Joseph Richie Hospi 5. Social Security Number 6. Sex 1 M 2	Ce 7. Age (In yrs. last birthday)	Ab. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Coui	place (State or Foreign ntry) vland
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town or Loc Baltimore		TAPLEL 23		1 ☐ Yes 2√ No
	ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. I: If item 27 is marked other than "natural," or Items 23s or 28e-f show for other traumatic event, It's Modical Exactions or attach an illied at	al Director	100. Street and Number 1301 Kent Avenue		10f. Zip Code 21207	10g	. Citizen of What Cour USA	ntry?
Maryland 21215-0036		by Funeral	Arried 2 Married 1 7	ged Forces? If Yes 2 ☐ No	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
		To Be Completed		lege (1-4or 5+) (Give I life. D	ent's Usual Occupation kind of work done during most of work IO NOT use retired)	ing	ib. Kind of Business/In B&O Railro	·
land 2			12 17. Father's Name (First, Middle, Last) George	Simms		e (First, Middle, Ma		
Mary			19a. Informant's Name/Relationship (Type, Pri Maude V. Simms (Wife	nt) 19b. Mailin	g Address (Street and Number or Rur Kent Ave., Baltin	al Route Number, C	City or Town, State, Zip	
Baltimore,			20a. Method of Disposition 1 25 Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem		Date 20	altimore,	
Baltin	permit. Pages 1 Department of He Important: If itan any injury or oth		21. Signature of Funeral Service Licanses	22	Name and Address of Facility Low	ıdon Park	Funeral H	ome
of Vital Records, P.O. Box 68760,	ding Physician: The law requires that the death certificate be executed by he attending physician and alter this certificate has been signed by the attending physician and large at the burial-transit are as the burial-transit.		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not entered on each line. Due to (or as a consequence of):	er the mode of dying, such as cardiag	or respiratory arrest	mets.	Approximate Interval Between Onset and Death
		dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of):				
		Physiclan/Medl	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
		ompleted by PI	Part II. Other significant conditions contributing	ng to death but not resulting in the un	derlying cause given in Part I.		2 No 3 Prob	
		C	25. Was case referred to medical		26. Place of Deat	performe 1 Yes 2 h (Check only one)	d? death?	2 No
		Certification: To B	1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) Date of Injury Injury	28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \) No	28d. Describe how		Hogice
	ital or Att irs after d ral Diract		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
	To tha Hospital or Attani within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	Medical	(Check only 2 Madical Examinar: Or	To the best of my knowledge, death the basis of examination and/or inv d manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur 29c. License number	red at the time, date	se(s) and manner as standard place, and due to be and place, and due to be a beautiful based. Date signed (Month,	the cause(s)
)	-318	111	John Mila	MARKO	D13012		6/9/02	5
	yrı		30. Name and address of curson who complete 31. Date filed (Month, Day, Lear)	32. Registrar's Signature	mondred I	Tothe,	1/1 2/	2/5
	Sta Regista		JUN 1 4 2005	person & A	porte			

Giles D. Simms

State of Maryland / Department of Health and Mental Hygiene ≥ 0.05 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** AITH, BELLEAMY, SIZEMORE 11.20 PM 08 2005 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UNIVERSITY OF MARTLAND MEDICAL BALTIMORE n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SYSTEM Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 4 Months Days 1 □ M 2√2 F Yrs. June 8, 2005 Maryland Director n/a Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than *netural', or items 23a or 28a-f show any injury or other traumatic event, the Modical Exist piner is used by notified at ORGE. 牧冠Yes 2□No Directo MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number n/a 21223 2004 Wilhelm St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 25No Specify: white Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Toni Marie Campagnoli Todd Matthew Sizemore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2004 Wilhelm St. Baltimore, Maryland 21223 Todd Matthew Sizemore- Father 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Aurial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery June 14, 05 Baltimore City * 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses .3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Party Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) TREME **Physician** /Medical Due to (or as a consequence of) Examiner HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit aoH D and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? for 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 2 □ No 2. No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 Ø No Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Diractor: 6 completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier en eluddeen 06,08,2005 22 S. GREENE BALTIMORE MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, Kanaluddeen. Wiversit Maireola 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

ORIGINAL

DHMH 17 Rev 1/200

			1 - State Registrar	State of Ma		partment of F ertificate of			ene 00	5 19789
			Decedent's Name (First, Middle, L.	ast)				2. Date of Death		3. Time of Death
	Physicia		Joseph	Samue1	Smit	h III		Month 6	9 200	12:25 A M
	/Medic Examin		4a. Facility Name (If not institution, g				r Location of Death		4c. County of I	
	Examin		Future Care Ch			Arnold			Anne	Arunde1
	Funeral			Sex 7. Age	e (In yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9.	Birthplace (State or Foreign Country)
	Director		220-60-9628	1 X M 2 ☐ F	52 Yrs	Months Days	Hours Min.	2/27/195	3	MD
	p .		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	I a a will a				1404 1-14-03-11-3-
	aryla shov	<u>_</u>		Arundel	Miller					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	8a-1	ecto	10e. Street and Number					140	. Citizen of Wha	
	a or	Funerai Director	405 Pixie Drive			10f. Zip Code 2110	Ω	100		t Country?
	eath	erai	11. Marital Status	12. Was Decedent E	ver in U.S.	3. Was Decedent of H		ocify Yes or No-	USA 14 Bace	American Indian,
10	tar d	-un-	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 N		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		White, etc.
21215-0036	urs al	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	white
Õ	2 ho	ted	15. Decedent's I		16a. D	ecedent's Usual Occup	ation	16	b. Kind of Busin	ess/industry
215	thin 7	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	+)	ive kind of work done e. DO NOT use retired	d) d)		Constru	otion
2	ed wil	Completed	12			Foreman				etion -
nd	ba filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Items 23e or 28e-f show event, the Modical Executiver, ust be rutified at	Be	17. Father's Name (First, Middle, Las				18. Mother's Name			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "naturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Executives and be multiply at once.	To	Joseph Samuel S					Jane McE		
Mai	12 sh h and 7 Is n traun		19a. Informant's Name/Relationship			ailing Address (Street				te, Zip Code)
	1 and Healt em 2 ther		Mrs. Bette J. Sm 20a. Method of Disposition	Itii / Motne	20b. Place of Di	Pixie Dr.,			ZIIU8 c. Location - Cit	v or Town. State
100	ages nt of :: If it		1 X Buriol 2 ☐ Cremation 3	Removal from State	cemetery,	crematory or other place idge Memor			Elkridge	
Baltimore,	artme ortani injury		'4 □ Donation 5 □ Other (Shed		f	22. Name and Addre	· · ·			
Ba	Depar Impor any ir		I duly	fle m	0137e4	1 Second A	Ave SW Gle		MD 2106	Home 51
			23a. Pant. Enter the disease, or conshock, or heart failure. List only	mplications that caused y one cause on each lin	the death. Do not ie.	enter the mode of dyir	ng, such as cardiac o	r respiratory arrest	t,	Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	a End	Sta	e Live	e dis	case		2-4-
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence					2 nem
		e	Sequentially list conditions,	b	s consequence of):	~				2 years
	ted nsit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Pan		ty Certas	Sion			2 yeur
Ć,	execun n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai I		d						
9	tificat g phy as th	ledi								
Вох	that the death certif ad by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 □Ectopic pregnancy	,		23d. Date of	· ·
<u> </u>	deat	sicia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐ Pregnant at 9☐ Unknown		5 Other (specify)	·		Month	Day Year
P.O.	at the by th	hy	9 Unknown							UI -
	es gu	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying cause giv	en in Part I.			te to the cause of death?
Vital Records,	w requir been si should	Completed						i Tes	2 X No 3 [Probably 4 Unknown
ec	e law has b	npie						24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
<u>=</u>		Co						performe	d? deat JNo 1□	Yes 2□No
ΞΞ Š	ysician: The	Be	25. Was case referred to medical examiner?	Hospital:		Dth	26. Place of Death			
o	Phys this al dii	To To	1 Yes 2 No	1 Inpatie		tient 3 DUA	4 Writing Hor	ne 5 Residence 28d. Describe how		Specify)
ם	ding l h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day		y Wor	k? Yes 2 □ No	LOG. Describe now	injury occurred	
Division	Attendi death. ctor; A y the fu	fica	3 ☐ Suicide 6 ☐ Could not	be 200 Place of Injur	ırv - At home, farm	street, factory, office		28f. Location (Stree	et and Number o	r Rural Route Number,
<u>S</u>	after after I Direct	Certification:	4 Homicide	building, etc	(Specify)			City or Town, S	State)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying F	hysician: To the best of	of my knowledge, d	eath occurred at the tir	ne, date and place, a	and due to the caus	se(s) and manne	or as stated.
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medicel Extone)	iminer: On the basis of and manner sta	ted.	r investigation, in my o	pinion, death occurre	ed at the time, date	and place, and	due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1-	Mn	29c. Licens		29d		fonth, Day, Year)
	^		, , , ,		> "	'	40579			10-05
	<i>'</i> 5		30. Name and address of person wh	completed cause of de	eath (Item 23a) (Ty	pe, Print)	disum P	ere Su	Te 100	Colen Barris
	- 0		31. Date filed (Month, Day, Year)	● Registra	r's Signature	, -, , , -				
	Sta Registr		JUN 1 4 20	05 Heres	D. A	ence				Glen Sarrie.

			1 - For State of Maryland / Department	artment of Health and M tificate of Death	lental Hygier	2000 1975	90
		-24	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of De	ath
	Physicia /Medic		Frances Marie Smit	hers	June 11	2005 8:22p	М
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
П			21000 Father Hurley Blvd # 222	Germantown		Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Fo	oreign
	Director		227-30-1503		July 9,	1922 Virgínia	
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City L	imits
	/anyli	ō				1 ☐ Yes 2]	
	the N	Directo	Maryland Montgomery Germantow 10e. Street and Number	7N 10f. Zip Code	100	Citizen of What Country?	
	with Re or	Ö					
	leath	Funerai	21000 Father Hurley Blvd, # 222 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20874 Was Decedent of Hispanic Origin? (Spr		nited States 14. Race - American Indian,	
(0	r Iter	Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No	Was Decedent of Hispanic Origin? (Spi f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.	
e e	al', o	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	I ☐ Yes 2 🔀 No Specify:		Specify: White	
20	filed within 72 hours after death with the Maryland Hygione. Ither then "natural", or Items 23a or 28a-f show ant, its Medical Exaction native notified	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	tent's Usual Occupation kind of work done during most of work	16b.	Kind of Business/Industry	
2	ithin 18.	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9		
2	ygien ygien t, Ille	Cor		gistered Nurse		Government	
Maryland 21215-0036	od ia b	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	en Sumame)	
<u> </u>	should and Men marke umatic	10	Benjamin Bray Smithers	Bertha H	-		
Jar	I 2 sh and I s m reum			g Address (Street and Number or Rura			
	s 1 and 2 should of Health and Men item 27 Is marke other treumatic		Barbara M. Ruppel/ Daughter 18819 20a. Method of Disposition 20b. Place of Dispo	Coral Grove Terr		antown MD 20874 Location - City or Town, State	
סַכ			1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crem	natory or other place)	17,05		
altimore,	permit. Pag Department Importent: I any injury o			tan Crematorium I	nc. Ale	exandria, Virgini	a
Ba	permit. Pag Department: Importent: If any injury o		21. Signature of Property Service Licenses	in L. Molesworth 401 Ridge Road, D	P. A. Fune	eral Home	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter			Approximate	
			shock, or heart failure. List only one cause on each line.		,	Interval Betwee Onset and Dea	
	Physician /Medical		disease or condition resulting in death) The property of the condition resulting in death) The property of the condition resulting in death) Due to (or as a consequence of):	Cancer		one ye	aj
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
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o	an ar		resulting in death) Last Due to (or as a consequence of):				
8760	cate be executed bhysician and the burial-transit	dicai	d				
<u> </u>	entific ling p e as t		IF FEMALE:				
Вох	attending p	ian/		Ectopic pregnancy		23d. Date of delivery Month Day Yea	r
o.	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as I	Physician/Me	1 Yes 21 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)			
٦.	that t		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of deat	h?
Vital Records,	uires sign Id be	d by			1 🗆 Yes	2 No 3 Probably 4 ZUnki	nown
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Re	The lav	щ			autopsy	prior to completion of caus	e of
			25. Was case referred to medical	OF Place of Dooth	1 Yes 2 2	No 1 ☐ Yes 2 🗹 No	
	ysicien: is certific director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death t 3 DOA Other: 4 Nursing Ho		6 □Other (Specify)	
ō	두 두 등	-	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how in		-
Ö	nding lath. r: After e funer	atio	11 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No			
Division of	or Atten after deatl Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number	;
ā	spitel or A ours after nerel Dire filled in by	Cer		<u></u>		·	
	Hospitel 4 hours a 1 unerel ely filled	edical	29a. Certifier (Check only (Ch	occurred at the time, date and place,	and due to the cause	(s) and manner as stated. and place, and due to the cause(s)	
	To the Hospitel within 24 hours a To the Funerel t completely filled	Medi	and manner stated.				
	5 ¥ 5 §	-	29b. Signature and title of Certifier	29c. License number	290, L	Date signed (Month, Day, Year)	
	a		TULL	033138	Ju	ne 13, 2005	
j			30. N e and address person who completed cause of death (Item 23a) (Type,	,	Mar1 - 1	2007/	
	Sta	te	Daniel A. Jaller MD 19504 Amaranth I 31. Date filed (Month, Day, Year) 32. Regigerar's Signature	Orive, Germantown,	maryland	20874	
	Registr		JUN 1 4 2005 Freque &	Sperte			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Vear **Physician** 52 PM mma dune. 2005 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore of Baltimore HOSPita Baltimor If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Hours Days 212-46-3685 Usual Residence of Decedent 1 M 2 F 936 South CAROLINA Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Examinar must be notified at 1 1 Yes 2 No ma Director more more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 Yes 2 No ō Baltimore, Maryland 21215-0036 Specify: Specify: 3 ₩idowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 is marked other then "no Elementary/Secondary (0-12) College (1-4or 5+) Vomestic mestic un Known nameer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sico Jance GEOral dWARd JEO YOUA 19a. Informant's ame/Relationship (Type, 19b. Mailing Address (Street and Number or Rur oute Number, City or Town, State, Zip Code) Department of Health an Importent: If item 27 is many in ury or other any in ury or other. K-WOWA KHeight. Ave ANE Agneu 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 6-9-05 Maryland MOUNT Chemel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDITH WYNT Funeral Servi th Belmar m01215 BALTMO Ave 23a. Part1. Enter the disease, or semplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician day /Medical Due La (or as a consequence of): Examiner nonte Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Can cer or Attending Physician: The law requires that the death certificate be executed Anorecta Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by heart Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hypertension 2□ No 2 No 1 Yes in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

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completely filled To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7, 2005 Kes-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai tos Pita iss-ha Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Charlotte Arme Stump Position				1 - For State Registrar		faryland / Dep Ce	partment of Fertificate of		!	Reg. No.	19792
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and of the V. A voyenar wy 100. 15/11 an 12 12h to my	10			30. Name and address of person v	vno completed cause of	death (Item 23a) (Type	(A.D.	-16 as	R 11.	Rl A	1/1/28
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2005 Dean Stanley Shingler June 6:30 A M 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10009 Carrigan Drive Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days **X**□M 2□ F Min. 501-14-1587 86 Director Yrs. 1918 North Dakota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neture!" ~--- any injury or other traumetic svent. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10009 Carrigan Drive 21043 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2☐ Married 1 Tes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jabez Martin Shingler Ellen Halcrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Zaloudek, P.O.A. 7955 Elvaton Road Glen Burnie, Maryland 21061 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory Inc. 06/11/05 Baltimore, Maryland 21. Signature Funeral Service License
Thomas Gregor ²², Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmo nury Onset and Death Immediate Cause (Final **Physician** Obstructive disease or condition resulting in death) Mronic yeurs /Medical Due to (or as a consequence of): Examiner Gaquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who com?

beller

2005

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rted cause of death (Item 23a) (Type, Print)

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32. Agistrar's Signature

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	°	+1	Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
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- 1	Funeral Director		5. Social Security Number (6.3)	M 2□F 7. Age	(În yrs. las 7	7 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Septemb	th iy, Year) ⊇r 1.192	9. Birth	nplace (State or Foreign untry) MD
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumetic avant, it a Madical Examination in colling any once.	Funeral Director	10e. Street and Number 2825 Lodge Farm F	Road Apt 40	8		10f. Zip Code	21219		10g. Citizen US		untry?
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rulvar, II	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (and Number or Rura				
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ű	Derr Imp		Vintley (. Con	rel	4 9	nnelly I	Funeral Ho ers POint	ome Of :	Dundal	k,P.A.	21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death.	Do not enter	the mode of dyin	g, such as cardiac o	or respiratory a	rest,	12/110.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CH	F							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequer	nce of):						
	LAGIIIIICI	<u>_</u>	Sequentially list conditions,	b. Large	Cel	1	MONEMI	Na				
B	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequer	ice or):						
-	te be executed ysician and e burial-transit	Exar	that initiated events resulting in death) Last	C. Due to (or as a	consequer	nce of);					-	
760,	ate be executed hysician and he burial-transit	call		d								
89	rtifica ng ph	Medi	IF FEMALE:		10,000							
õ	eath certifica attending ph for use as tt	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of			ctopic pregnancy				Date of deliv	,
P.O. Box 68	the al	sicl	1 Yes 2 No	4⊡Pregnant at t 9⊡Unknown	ime of deat		Other (specify)				Month	Day Year
9.	that the ed by detac	by Physiclan/Med	Part II. Other significant conditions of	ontributing to death but	t not resulting	ng in the unc	lerlying cause give	en in Part I.	23e. Did to	obacco use c	ontribute to	the cause of death?
Division of Vital Records,	Attending Physician: The law requires that the death certifica r death. actor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the						, ,		1 🗆 🗎		/	bably 4 Unknown
<u>ွ</u>	aw requ s been s should	Completed							24a. Was		b. Were aut	opsy findings available
8	The lav	om							autop perfor	rmed?	prior to co death? 1 Yes	ompletion of cause of
ita /	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of Death				2010
of \	Physic this co	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatien		VOutpatient		er: 4 Nursing Hon				fy)
, L	ding F	lon	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injury Work	k?	28d. Describe h	low injury occ	curred	
isi	al or Attendi after death. I Diractor: A d in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not b		v - At home	e, farm, stree		Yes 2 □No	28f. Location (S	Street and Nu	mber or Rur	al Route Number,
o Significant distribution of the significant distribution of	i Sir e	Certification	4 Homicide	building, etc.	(Specify)	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,		City or Tow	m, State)		a, 1100.10 11001,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysicien: To the best of niner: On the basis of	my knowle	odge, death o	occurred at the time	ne, date and place, a	and due to the	cause(s) and	manner as s	stated.
	the H hin 24 the F aplete	Medical	0110)	and manner state	ed.	- and/or mive			· · · · · · · · · · · · · · · · · · ·			
	To To	_	29b. Signature and title of certifier	1 / -	n	ND	29c. License		1	29d. Date sig		
	0,		30. Name and address of person who	completed saves of di-	ath /lto or	30) (T.m. C	Doos	8631		6-1	0-2	003
	10		DY ISINE and address of person who	Awada a	(NOM 23	FCOIA	Min So:	1010 Tri	ve B	2 Him	ice in	005 1D. 21237
	Sta	te	31. Date filed (Month, Day, Year)	2005 32. Resistrar	's Signature	e de la		791 - 211	, 00	~ 110+1	1-11	TO MOUI
	Registr	ar	JOIN T 4	LUUJ MARIN	KU S	J. All	SHELD.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 10 2005 Sharon Lynn Sandler /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Levindale Hebrew Geriatric Ctr&Hospital Baltimore Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Days 1 □ M 2 XF Director 53 155-46-9343 06/04/1952 PA Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be multilled at 10d. Inside City Limits 1 XYes 2 No MD Baltimore City Baltimore Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death 21215 Funerai 2434 W. Belvedere Avenue United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural', or iten any injury or other traumatic event, the Medical Examina. once. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No ģ Specify: 3 □ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Custodial Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Sandler Mae E. John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Sandler /Brother 5120 E. Hampton Avenue # 1207 Mesa, AZ 85206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jun 13 * 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2005 21. Signature of Funeral Service License PORM 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Latraven resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury SIO Examiner a consequence signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe After this certificate 1 Yes 2 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Certification: 28b. Time of 28c. Injury at Work? Manner of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mec -n 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

				Please	Type or Pri	nt in Black	Inde	lible Ink.	Ensure A	II Copies	Are	Legible.		
		_		1 - For State Registrar		aryland / D		ment of H			Reg. N		197	96
	eri	Physic	ian	Decedent's Name (First, Middle, La Erroreit	·					2. Date of De Month	D	ay Year	3. Time of	
		/Medi Examir		Everitt B. Smin 4a. Facility Name (If not institution, gin)	4b	City Town or	Location of Death	June		c. County of Death	5:30	AM "
		Examir	ier	Broadmeade Nu:				ockeys				Baltimor	:e	
		Funeral Director		5. Social Security Number 6. 3 272-18-7291		ge (In yrs. last birth	day) If		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, De Jan 5,	ey, Year		place (State ontry) York	or Foreign
1		and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	on					10d. Inside Ci	ity Limits
0		Mary -1 sho fied s	tor	MD Baltim	ore	Cocke	ysvi:	11e					1 🗆 Yes	
18/6		h with the M 3a or 28a-f	ai Direc	10e. Street and Number 13801 York Road	#H10			Of. Zip Code 210	30		10g. C	itizen of What Cou USA	ntry?	
8	. 9	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or Items 23a or 28a-f show event, the Modical Extrating ministics notified.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Armed Forces? 1 Zeves 2 If Yes, Give	No	_	Decedent of His, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White,	etc.	
i	9	72 hours natural',	d b	3 Widowed 4 Divorced	Year or Dates:	'43-46							nite	- 4
30 trui	21215-0036	in 72 n "nat	plete	15. Decedent's E (Specify only highest gr	ade completed)		Decedent: Give kind life. DO N	s Usual Occupa of work done of NOT use retired	ation during most of work ()	ing	16b. I	Kind of Business/In	dustry	unk
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9	yla	2 should be find and Mental Men	2	Everitt B. Smi					Anne Na					
ba	, Maryland	and ealth n 27		Barbara Smith/s	* -	13	3801	York Re	oad #H10	Cockeys		or Town, State, Zip 1e, MD 2	21030	
April	altimore,	Page nent o nnt: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Speci		20b. Place of D cemetery,	Disposition cremator	n (Name of ry or other plac		Date	20c. L	ocation - City or To	iwn, State	
Ø	Balt	permit. Departr Imports any inju		21 Signature of Funaral Service Lice Ronald S	Wade, Fir	9503	Stat Balt	me and Address e Anato imore,	omy Board MD 2120	655 W.	Ва	ltimore S	treet	
•		Physician /Medical		23a. Paq1. Enter the disease, or conshoot, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. P	d the death. Do no no ne. AN CRA a consequence of	EAT		g, such as cardiac		rrest,		Approximate Interval Betwonset and E	ween
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j,	,092	e be executed sician and burial-transit	sal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of)):							
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(V)	.O. Box	ne death cei the attendir hed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetal death		opic pregnancy er (specify)				23d. Date of delive Month		Year
utt	Records, P	w requires that the bear signed by should be detact	by	Part II. Other significant conditions of DIADUS	contributing to death b	but not resulting in the	he underh	ying cause give	n in Part I.	23e. Did t		use contribute to th	ne cause of de	
7	000	law requ as been 2 should	piet	Colon	sncer					24a. Was		24b. Were auto	psy findings a	available
6	R	iician: The lav certilicate has rector, page 2	Completed	Prostatu	Concer					autoj perfo 1 □ Yes	psy ormed? 2[]/No	death?		ause of
(1)	Vital	cian: ertific actor,	Be (25. Was case referred to medical examiner?					26. Place Deatl	Check only	one/			
W	of	Physician: this certificatal director,	. To	1 Yes 2 No	Hospital:			DOA Othe	4 a ursing Ho			6 ☐Other (Specify	0	
		Attending Physic death. sctor: After this by the funeral di	tion	1 Latural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	y Year) 28b. Tin Inju		28c. Injury Work	at ? ∕es 2 □ No	28d. Describe	now inju	iry occurred		
	Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm c. (Specify)	n, street, f			28f. Location (. City or Tox	Street al	nd Number or Rura e)	l Route Numt	ber,
		To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 D Certifying Ph (Check only one) 2 Medical Example 1	nysician: To the best miner: On the basis o and manner sta	f examination and/	death occi or investig	urred at the tim gation, in my op	e, date and place, inion, death occurr	and due to the ed at the time,	cause(s date an	i) and manner as si d place, and due to	ated. the cause(s))
		To the within 2 To the comple	Me	29b. Signature and title of certifier	0	1000	`	29c. License	number		29d. Da	ite signed (Month,	Day, Year)	
		-		Barbara	. Carre	ll, the)	DE	38392	To the state of th	6	0/8/2	305	
				30 Name and address of person who	completed cause of d	leath (Item 23a) (T)	/pe, Print)	1 YOF	RK RD.	, COCK	KEI	15 VILLE	E, MI	030
	. 5	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 20	105 Registr	ar's Signature	post				7		,	

State of Maryland / Department of Health and Mental HygieRe Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Schultz 2005 LUGENE JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Yrs unk Director 214-30-0311 Feb 18, 1933 Usual Residence of Decedent the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show MD 1 ☐ Yes 2 ☑ No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 5721 Grosvenor 20814 by Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces?

1∑ Yes 2 □ No If Yes, Give Year or Dates:

15 2 − 15 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other treumatic event, tra Medical Examina Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 152-53 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) taxi driver unk transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Lett/friend 11504 Goodloe Road Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 XOther (Specify) in state 21. Signature of Funeral Serv State Anatomy Board 655 W. Baltimore Street Director mari 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY Physician EMBOLISM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Uruerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy 1 ☐ Yes 2 ☐ Wo 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death To the Hospital or Attending F within 24 hours after death.
To the Funerel Director: After i 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057124 Za (lub 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRUCKS BOOL NO 13219 EXECU D 13219 Executive PK Terr, Germantown MD 1 Rugno BOC 31. Date filed (Month) Day, Year) State JUN 1 4 2005 Registra

Schultz, EUGENE

			For L_ State	State of Maryland / [Department of Health and I	Mental Hygie	ene 005	19798
			Registrar		Certificate of Death		. No.	
	Physici	an	1. Decedent's Name (First, Middle, a		. 0.0/./	2. Date of Death Month	Day Year	3. Time of Death
	/Medio	_	4a. Facility Name (If not institution, of	nive street and number)	4b, City, Town, or Location of Death		4c. County of Death	1.48 1
	Funeral Director			. Sex 7. Age (In yrs. last bir		8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	lace (State or Foreign try) 4ROLINA
	yiand Now		10a. State 10b. County	10c. City, Tow	n or Location		1	0d. Inside City Limits
	r 28e-f show	Director	10e, Street and Number	imore '	PARKVILLE 101. Zip Code	100	. Citizen of What Cour	1 □ Yes 2 No
	23a or	al Di	2024 Wyel	iffe Rd.	21234		USA	
36	after dea or ttems primer m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widówed 4 🛱 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify	
2-00	n 72 hours "neturel", e-Jical Era	eted	15. Decedent's (Specify only highest	Education 16a	Decedent's Usual Occupation (Give kind of work done during most of work	kina 16	b. Kind of Business/Inc	dustry
21215-0036	filed within Hygiene. ther than " int, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	nderwiter		Insura	nce
Maryland 3	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other treumatic avent, the M	To Be C	17. Father's Name (First, Middle, La	akley	18. Mother's Nan	ne (First, Middle, Ma		
Man	12 sho h and l 7 Is ma		19a Informant's Name/Relationship	(Type, Print) 19b	. Mailing Address (Street and Number or Ru	ral Route Number, C	City or Town, State, Zip	Code)
	s 1 and 2 f Health Item 27 other tre		20a. Mathod of Disposition	- cameta	f Disposition (Name of ry, crematory or, other place)	Date 20	c. Location - City or To	wn, State
Baltimore,	Page ment o tent: If		1 Burial 2 Cremation 3 `4 Donation 5 Other (Spe	Hemoval from State /)	ierra Cemeters lo-	16-05 1	Parkville	MA
Ball	permit. Pages Department of I Importent: If Ite eny Injury or of		21. Signature of Funeral Service Lie	241	22. Name and Address of Ficility		MO 212 ?	
	- 14		23a. Part1. Enter the disease, or shock or heart failure. Listor	omplications that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest	8WHARFOR	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a SEPTIC SH	OCIC			Onset and Death
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,8760,	icate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. LOSTER DION Due to (or as a consequence		AT S		
.O. Box 68	Attending Physicien: The law requires that the death certificate releath. sctor: After this certificate has been signed by the attending phy. by the funeral director, page 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>a</u> .	es that the igned by be detact	by Ph	Part II. Other significant condition	s contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
ords	w requires been sign should be	ted b	IDIOPATHIC !	THROMBOCYTUPE	NIC PURPURA	1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Inknown
of Vital Records,	The law rate has be page 2 sh	Completed	CORONARY	ARTERY DISEAS		24a. Was an autopsy performe	prior to con	psy findings available npletion of cause of
tal	sicien: Th certificate rector, pag	0	25. Was case referred to medical	E HEART FAILL			No 1 ☐ Yes	2 No
f Vi	hysicie this cer al direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/O	utpatient 3 DOA Other: 4 Nursing H		ce 6 □Other (Specify	/)
ion o	nding Ph ath. r: After th e funeral	atlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year)	Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		
Division	el or Attendi s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be ed 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospitel or Attendity within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Centifier 1 Centifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge caminer: On the basis of examination are and manner stated.	e, death occurred at the time, date and place id/or investigation, in my opinion, death occu	, and due to the causerred at the time, date	se(s) and manner as st a and place, and due to	ated. the cause(s)
	of the company of the	Σ	29b. Signature and title of certifier	Kunstla MI	29c. License number		. Date signed (Month,	
	1		30. Name and address of person w	no completed cause of death (Item 23a)	(Type Print) SUZTITH KUR	DV/1CLA	TUNE 12th	
	0 "		GICCU SAMAR	TIAN MOSPITAL, S	GOI LOUH RAVEN BO	ULEVARD	MD 212	39
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32 Registrar's Signature	Sparke			

TANNEY, EVELYN

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** June 2005 Margaret K. Tolzman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 830 Fairway Ave. Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-22-1922 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Director 82 217-14- 1539 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show r than "natural", or itame 23a or 28e-1 show the Wedical Examinar qual be politied at 1 ☐ Yes 2 😾 No Catonsville Maryland | Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 5446 Wilkens Ave. filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHite 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Education Secretary 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other treumatic event, 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Engel Harry Kynast 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 830 Fairway Ave., Catonsville, MD Linda Gallagher/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 □ Cremation 3 □ Removal from State 6-10-2005 Baltimore, MD Loudon Park *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21228 1630 Edmondson Ave., Catonsville, MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or cour lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner nt ones Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi the attending physician and Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 100
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🕽 1 Yes 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ofter death Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funerel D Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DS0303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 Fredorial Rd Ste 162, 21228 NANDE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 Registrar 4 2005 Joseph

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

ORIGINAL

			for State Registrar	State of Maryla	and / Department of I		Hygiene Reg. No: 005	19800
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle Rober + 4a. Facility Name (If not institution	Warren	Whitaker 4b. City, Town, PAR	2. Date Month JU or Location of Death	of Death h Day Yea 11 200 4c. County of De	5 1.20A.M
	Funeral Director		5. Social Security Number 220-22-1390 Usual Residence of Decedent	6. Sex 1 M 2 □ F	yrs. last birthday) If Under 1 Year Months Days	Hours Min. 8. Date	In, Day, Year)	Birthplace (State or Foreign Country) Sew Jersey
	the Marylan 28a-f show	ector	10a. State 10b. County BACT 10e. Street and Number	TMORE 100.	City, Town or Location PARKUI 10f. Zip Code	le	10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28a-f show or other treumetic event, the Medical Examinations in collising a	Funeral Director		12. Was Decedent Ever in Amed Forces?	2	1234 Hispanic Origin? (Specify Yes pan, Mexican, Puerto Rican, etc	USA	merican Indian,
21215-0036	72 hours aft 'naturel', or dical Exami	b	3 Widowed 4 Divorced 15. Deceden (Specify only highes	If Yes, Give Year or Dates:	1 ☐ Yes 2 No 16a. Decedent's Usual Occu (Give kind of work done		Specify: U	Shite.
	e filed within I Hygiene. other then "	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle,	College (1-4or 5+)	Auto Sal	eS 18. Mother's Name (First, M	Automo	stive.
Maryland	2 should be and Mental Is marked o	ToB	R. Warren 19a. Informant's Name/Relations			Mabel E t and Number or Rural Route N	. Haines	e, Zip Code)
	Pages 1 and 2 nent of Health a ont: If item 27 la iry or other trea		20a. Method of Disposition		b. Place of Disposition (Name of cemetery, crematory or other pla	St Avr. Par	20c. Location - City	
Baltimore,	permit. Pag Department Importent: I any injury o		*4 □ Donation 5 □ Other (S _i 21. Signature of Funeral Service		u laily Nalley Moyu.	00.011	Timovium ORE, MD 212 SECHARFORD	234.
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. Light Immediate Cause (Final disease or condition resulting in death)	complications that caused the donly one cause on agch line.	death. Do not enter the mode of dyi			Approximate Interval Between Onset and Death
	/Medical Examiner	J.		Due to (or as a cons				7,
8760,	ate be executed hysician and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons				
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of predictions of the state of the s	etal death 3 Ectopic pregnanc	у	23d. Date of o	delivery Day Year
Δ.	w requires that in been signed by should be detail	by	Part II. Other signifigant condition	ns contributing to death but not i	resulting in the underlying cause gr		Did tobacco use contribute	to the cause of death? Probably 4 Denknown
Vital Records,	. a r	Completed					autopsy prior to death	
of Vit	Physicien: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		Z DENOUIPALIENT 3 DOA		Residence 6 □Other (Sp	pecify)
Division	Attending r death. ector: After by the funer	Certification:	27. Mann of Death 1 atural 5 Pendin 2 Accident Could r 3 Suicide 6 Could r 4 Homicide dete	atio	M 1 C	Yes 2 □ No 28f. Locati	ribe how injury occurred ion (Street and Number or and Town, State)	Rural Route Number,
ā	Hospital 4 hours Funerel ely filled	edical Cer	29a. Certifier 1 1 ertifyin (Check only one) 2 Medical I	g Physician: To the best of my k Examiner: On the basis of exam	knowledge, death occurred at the ti	me, date and place, and due to	the cause(s) and manner	as stated. ue to the cause(s)
	To the Hos within 24 hr To the Fun completely	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	29d. Date signed (Mo.	nth, Đấy, Year)
	6		30. N me and address of person	who mpleted cause of death (I	Item 236) (Type, Print)	BA BULL	11/2	1710
	Sta Registr	te ar	31. Date filed (Month, Day, Tear)	2005 32 legistrar's Sig	gnature Good	THE WOTTE	71111 1	

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Williamson) one 3.12 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Anne Arund alen North arundal Huspital BUNNO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Country) 1□M 25 F 69 Yrs. Director 222-20-1944 19, 1935 DE Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Mudical Exercitive Traist be notified at 1 ☐ Yes 2 X No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 7954 Crownsway 21061 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give — Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or liter any injury or other traumatic event, the Mudical Exertine"? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Louisa Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard J. Williamson - Husband 7954 Crownsway Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial Cremation 3 Removal from State 5 Other (Specify) Chesapeake Cremation | 06/11/2005 Stevensville, MD 22. Name and Address of Facility Singleton Funeral Home 21. Signatu of Europeal Shrylor 201190 1 Second Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) congestive heart Physician /Medical Due to (or as a consequence of): Examiner 6 hours acute my ocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes Hospital or Attending Physiclan: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After ! Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours a 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s), and manner stated. (Check only one) To the ! within 2 To the title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and D00224£ 8,2005 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Dr. Glen Burnie, MD 2106 305 32. Pagistrar's Signature State Registrar

			1 ≃ For State Registrar	State of N	-	epartment of Certificate of	Health a		ntal Hygi	ene) () ()5	19802
ı	Physici		1. Decedent's Name (First, Middle, Ernestine		Warner				Date of Death Month une 09	Day 200	Year 5	3. Time of Death 11:45 A M
	/Medic Examir		4a. Facility Name (If not institution,	give street and number	or)	4b. City, Town,	or Location o	f Death		4c. County of	of Death	
	Funeral Director		Mariner Health 5. Social Security Number 220-30-8662		Age (In yrs. last birth			24 Hrs. 8. Min. M	Date of Birth (Month Day, IBY 06 I	Balt 933	imor 9. Birthp Cour Mar	e place (State or Foreign ntry) yland
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town							
	Aaryla r shov	ō	MD Baltin	nore	Balti							1 ☐ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number		Dares	10f. Zip Code			100	j. Citizen of W	hat Cour	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show simply injury or other traumatic evant. It is Madical Examinator must be notified at ance.	Completed by Funeral Director	8418 Maymeadov 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force	s? Two	13. Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican	gin? (Specif , Puerto Ric	Uni y Yes or No- an, etc.)	14. Race	- Amend , White,	of America can Indian, etc. ite
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br	d 2 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic evant, it e Mas	Be C	17. Father's Name (First, Middle, L				18. Mothe	r's Name (F	First, Middle, Ma	iden Sumame)	
ylaı	Menta Menta arked	70 [Anthony Prezi	loso					e Liber			
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationsh Ezra J. Wan			Mailing Address (Stree						
	1 and Health Iam 27 other to		20a. Mathod of Disposition	ner (sp	20b, Place of I	18 Maymead Disposition (Name of	!	Date	1987	e, Mar		
ē.	Pages ent of nt: If II		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		te Lake Vi	ew Memoria	1 Pk	06/13				
Baltimore,	permit. It Departm Importar any injur		21. Signature of Suneral Service L				ess of Facility	Lori	ng Byer	s Fune	ral I	Directors, I
K			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus only one cause on each	ed the death. Do no	ot enter the mode of dy	ring, such as	cardiac or re	espiratory arres	t,		Approximate Interval Between
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90,	cate be executed physician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cluss (Lisease Vijus) that initiated events resulting in death) Last	c	as a consequence of							
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.O. Box 6	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregnant 5 □ Other (specify)	су			23d. Date Mon		ery Day Year
ecords, P.	w requires that the di been signed by the should be detached	by	Part II. Other significant condition	Is contributing to death	but not resulting in	the underlying cause g	iven in Part I.			cco use contri		ne cause of death?
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of	Phys this al di	. To	1 Yes 2 No 27. Manner of Death		itient 2 ER/Outp	Datient 3 DOA			5 Resident			y)
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Division	To the Hospital or Attendii within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of	Injury - At home, farr etc. (Specify)	n, street, factory, office		28f.	Location (Stre City or Town,		r or Rura	V Route Number,
	To the Hospital or within 24 hours after the Funaral Director than Funaral Director tompletely filled in the completely filled in the funaral birector than the funaral birect	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	of examination and	death occurred at the for investigation, in my	time, date and opinion, deat	d place, and h occurred	I due to the cau at the time, date	se(s) and man and place, ar	ner as si	tated. o the cause(s)
)	ro tro tro	×	29b. Signature and title of certifier	~0. 9t	tenti-f	29c. Licer	6 9 4	2		Date signed		Day, Year)
10)		30 Name and address of person v	mo completed cause of	f death (Item 3a) (The second of the second	ype, Print) Cet	cy. U	le , /	No 21	228		
	Sta Registr		31. Date filed (Month, Day, Year)	1 4 2005 32. Regi	Grar's Signature							

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2005 9:00 P M June 8. Margaret Hayes Washington /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Broadmead **Baltimore** Cockeysville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 X F 97 Director 579-64-4648 May 10, 1908 Pennsylvania Usual-Residence of Decedent death with the Maryland 10c. City. Town or Location 10d Inside City Limits 10a State 10h County 28a-f show other traumatic event, the Medical Experimentment be nutified at 1 ☐ Yes 2 X No Director Cockeysville Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Items 23a 21030 13801 York Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 😿 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fith Department of Health and Mental Hy Importent; If Item 27 Is marked oth any july or other traumatic event angers. Be J. Kenderdine Margaret McKinney ပ Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Walter Washington II/Son 8382 Middle Way Pike, Charles Town, WV Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) Mt. Comfort Crematory 5/10/05 Alexandria, Virginia ^¹ 4 □ Donation 21. Sinnat a of Funeral/Service Licens 22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley Inc. Clary bryan W 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. En' rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Or set and Death Immediate Cause (Final disease or con resulting in death) **Physician** mon /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 12 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performed? 1 Yes 2 7 No of Vital 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) Hospital: Other: 4 Dursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 3□ DOA 1 Tyes 1 Inpatient 2 ER/Outpatient SIL 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending 1 I Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely and manner stated. the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 2005 31. Date filed (Month, Day, Year) State Registrar

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н	Physici /Medio		Irma H	elen Wea	ammer	t			June 9	Day 200)5	10:30 P ^M			
2	Examin		4a. Facility Name (If not institution, giv	e street and numbe	r)		4b. City, Town	, or Location of Dea		-	County of Death	10.30 1			
%.			Pickersgill R								Balti				
A.F	Funeral		5. Social Security Number 6. S 217-14-5984	6ex 7. / □ M 2 1 F	Age (In yrs.	last birthda 3 Yrs.	Months Day		. (Month, Da	ay, Year)		place (State or Foreign htry)			
	Director		Usual Residence of Decedent		C	0 4			JUN 16	, 192	22 Mary	yland			
	ryland how		10a. State 10b. County		10c. Ci	ty, Town or	Location					10d. Inside City Limits			
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9	ours a	Completed by Funeral Director	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates			1□Yes 2💢N	o Specify:			Specify: W	hite			
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9	filled v Hygie other t	ပိ	17. Father's Name (First, Middle, Last,)		K	etail C	7	me (First, Middle			t Store			
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I have not them 23s or 28e-f show umatic event, the Madical Evertiner must be notified.	To Be	Ignatius Jose	eph Bayl	ine				len Flo		,	ser			
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	and 2 saith a n 27 is		Bruce J. Weamme	ert/Son			Chalet	Circle	West M	iller	sville,	MD 21108			
ore	es 1 of He If iten		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □	Removal from Stat		Place of Dis cemetery, c	sposition (Name of crematory or other p	lace)	Date	20c. Loc	ation - City or To	own, State			
Ē	Pag tment tent: jury c		`4 ☐Donation 5 ☐ Other (Specif	y)	Me		Crematory				timore,	MD			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 le marked other then "naturel", or Items 23s or 28e-f show any injury or other traumatic event, the Madical Evaniner must be notified anyone.		21. Signatury of Fur eral Service Licer	corchik			22. Name and Add Cremation 299 Frede	ress of Facility Society Arick Road	of MD,	Inc.	MD 2122	8			
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9			JF FEMALE:	F4:											
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ta	hystcien: The Ia nis certificate ha: I director, page 2	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o		10.143	ZENO			
<u>~</u>	hysic his ce	ို	1 □ Yes 2 📉 No			ER/Outpat	ient 3 DUA		Home 5 ☐ Resid	dence 6	Other (Specify	y)			
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.		29a. Certifier 1 Certifying Ph	ysician: To the bes	st of my kno	wiedge, de	eath occurred at the	time, date and plac	e, and due to the	cause(s) a	and manner as st	ated.			
	the Ho in 24 the Fu pletel	edicai	(Check only 2 Medicel Examone)	niner: On the basis and manner	of examina stated.	ition and/or	investigation, in my	opinion, death occ	urred at the time,	date and p	place, and due to	the cause(s)			
	To T To T	Σ	29b. Signature and title of certifier	1 100				nse number			signed (Month,				
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show any Injury or other traumelte event, I're Midical Examinational Remodified at Once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □Wes 2 □ ! If Yes, Give Year or Dates:		If Yes, s	cedent of His specify Cubar s 2 No	spanic Origin , Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A Black, W Specify: 1/2	/hite, etc	
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Вох	The law requires that the death certifule has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Unknown} \)	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ⊟Ectopic 5 □ Other	pregnancy (specify)				23d. Date of Month	delivery Da	y Year
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director. After this certifica completely filled in by the funeral director, p.	edical (29a. Certifier 12 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ter: On the basis of and manner sta	examination and/	leath occurr or investigat	ed at the time ion, in my opi	, date and p nion, death o	place, and due to the	e cause(s e, date an	s) and manner od place, and d	as state	d. e cause(s)
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			1 - For State Registrar		aryland / Dep <i>Ce</i>	artmen			and M	F	leg. No.	05	19806
H	Physici	an -	Decedent's Name (First, Middle, Marie A. Wa							2. Date of Dea Month	Day	Year	3. Time of Death
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	Examir	ıer	1901 Searles Ro				dalk		Death			timore	
	Funeral Director		5. Social Security Number 213–05–3282	5. Sex 7. Ag 1 ☐ M 2 💢 F	ge (In yrs. last birthday 87 Yrs.) If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day Feb. 1	, Year) , 1918	9. Birth Cou Md	place (State or Foreign intry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	he Maryli 8a-1 sho ciffied a	ector	Md. Balti	more	Dundal	k							1 □ Yes 2 No
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920	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or Itams 23a or 28a-1 show event, the Mcdical Examirer i ust be notified at	b	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces d 1 Yes 2 2 If Yes, Give Year or Dates:	2	Was Deced If Yes, spec	ify Cuba	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		ace - Ameri lack, White city: Wh	
Maryland 21215-0036	within 72 ho ene. than "natur he Modical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Giv life.	edent's Usua e kind of wor DO NOT us	rk done d se retired	turina most	t of workii	ng	16b. Kind of		ndustry
and 2	ild be filed within lental Hygiene. 'Ked other than ic evant, Ins M.	Be	8 yrs. 17. Father's Name (First, Middle, La Carl Salkowski		П	Jusewi	те	18. Mothe Pear	r's Name	(First, Middle, alkowski	Home Maiden Sum		
Mary	d 2 shouth and N 17 is mer traumat	Ī	19a. Informant's Name/Relationshi Dennis Collins	(Type, Print) Jr. great	t great 196. Mai	ing Address	(Street a	and Numbe	or or Rura	Route Numbe	r, City or Tow	m, State, Zi	p Code)
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If itam 27 is marke any injury or other traumatic once.		20a. Method of Disposition 20a. Method of Disposition Cremation 4 □ Donation 5 □ Other (Special Control Co	☐Removal from State	20b. Place of Disp	osition (Nan	ne of	1	June		20c. Location Baltin	n - City or T	own, State
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	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best miner: On the basis of and manner st	f examination and/or i	th occurred anvestigation,	at the tim in my op	e, date and pinion, deat	d place, a	nd due to the cod at the time, d	ause(s) and r ate and place	nanner as s a, and due t	stated. o the cause(s)
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	Sta Registr		31. Date filed (Month, Day, Year)	2005 32 Aegistr	ar's Signature	NAME!	•		,				

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			Registrar 1. Decedent's Name (First, Middle,	Last)		061	unicate of L	Jeani		2. Date of Death	g. No.		3. Time of Death
	Physic		Jani		nett	TA7 5.7	att			Month June	Day	Year 0 0 5	3:36 AM
	/Medi Examir		4a. Facility Name (If not institution,			vv y d	4b. City, Town, or	Location o	of Death	o une	4c. County of		3:30 A
ı	LXaiiiii	101		lemorial		tal	Freder				Fred		n le
	Funeral			S. Sex 7	Age (In yrs. la:		If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign
	Director		154-03-6677	1□M 2∏F	86	Yrs.	Months Days	Hours	Min.	(Month Day, Apr 28,	1919	New	Jersey
	pu »		Usual Residence of Decedent 10a. State 10b. County		40-00	_							
	aryla shov	7		• 1	Toc. City,	Town or Lo						1	Od. Inside City Limits
	the N 28a-f	Director	MD Frede	rick		Fred	erick						1 □ Yes 2 □ No
	be filed within 72 hours after death with the Maryland nat Hygiene. sd other than "natural", or Items 23a or 28a-1 show avent, the Medical Examere rust be notified at	급	7401 Willow Ro	ad			10f. Zip Code	2170	11	10	g. Citizen of W	hat Coun	try?
	ns 23	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13 \	Was Decedent of His			cify Yes or No.	USA	- Amoric	an Indian,
'	fter d	돌	1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?	1	Was Decedent of His Yes, specify Cubar	n, Mexican	, Puerto F	Rican, etc.)		, White,	
21215-0036	eal', o	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates	_		∏Yes 2∏ No	Specify:			Specify:	wh	ite
9	72 ho natur icul	Completed by	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual Occupa kind of work done di	ition	and area adulas	11	6b. Kind of Bus	iness/Inc	iustry
7	ithin Ben *	ם	Elementary/Secondary (0-12)	College (1-4c	r 5+)	life. L	OO NOT use retired)	uning most	OF WORKIN	g			
7	ed wygien ygien yer th	S	12		5+	adm	inistrati						ucation
	be fill d ott	Be	17. Father's Name (First, Middle, La							(First, Middle, Ma)	
<u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </u>	ould Men varke	ို	Martin Wilbur							ay Westo			
Maryland	12 sh h and f is n		19a. Informant's Name/Relationship	. ,, ,			g Address (Street a.						
	1 and Healt Bm 2 thar		Melvin Bennett/ 20a. Method of Disposition	brotner	20h Plac		Baker Ci	rcle					21710
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Mariteal Exempliant must be notified at anone.		1 ☐ Burial 2 ☐ Cremation 3			netery, cren	natory or other place	9)		20	oc. Location - C	ity or 10	wn, State
≣	artme ortan injury		' 4 ☑Donation 5 ☐ Other Spe		-4	22	Name and Address	s of Escilib	,				
ä	permi Depa Impo any ir		21 Signatus Ronald S	Wades ME	retor	S	Name and Address tate Anat altimore,	omy]	Board 2120	1 655 W.	Baltim	ore	Street
			23a. Part 1. Enter the disease, or co	omplications that caus	ed the death.						t.		Approximate
	Physician		Immediate Cause (Final	nly one cause on each	line.	. /	7 0	,					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	as a conseque	nce of):) nu	sene				9	yrs:
	Examiner		One of Bullion States			,.							V
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a conseque	nce of):							
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
Ő,	cate be executed physician and the burial-transit	ă	resulting in death) cast	Due to (or a	is a conseque	nce of):							
8760	8 5 E	dlcal		d									
ox e	ding	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnanc	3/						- 1	
ñ	death certifi e attending I id for use as	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ☐ Fetal de at time of deal	eath 3 🗆	Ectopic pregnancy Other (specify)				23d. Date Mont		ry Day Year
o.	0 0	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	at time or again	an 5_	Other (specify)						
J.	s that ned b	by Pt	Part II. Other significant conditions	s contributing to death	but not resulti	ng in the un	derlying cause giver	n in Part I.		23e. Did toba	cco use contrib	ute to the	e cause of death?
ecords,	requires that the een signed by th nould be detache									1 🗀 Yes	2 X No 3	☐ Proba	ably 4 □Unknown
ပ္ပ	s b	ompleted								24a. Was an	24b. W	ere autop	sy findings available
T	The lav									autopsy performe	gri de	or to com ath?] Yes 2	spletion of cause of
Vital	sician: The k certificate ha irector, page 2	BeC	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes 2 (Check only one)	No 1L	1195	No
o	Q 2. X	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpai	tient 2 EF	VOutpatient	3 DOA Other	4 🗆 Nur	sing Hom	e 5 Residenc	ce 6 □Other	(Specify))
		on:	27. Manner of → ath Natural 5 □ Pending	28a. Vate of In (Month, D	jury 28 Pa <i>y Year)</i>	Bb. Time of Injury	28c. Injury : Work?	at ?	28	ld. Describe how	injury occurred	i	
<u> </u>		catl	Accident investigat	be				es 2⊡N	lo				
DIVISION	or At after d Diract in by	ertification;	4 Homicide determine	ed 28e. Place of II	njury - At home etc. <i>(Specify)</i>	e, farm, stre	et, factory, office		28	If. Location (Street City or Town,	et and Number State)	o <i>r Rur</i> al	Route Number,
	Hospital or 24 hours after Funaral Dir tely filled in	O	29a. Certifier 1X Certifying	Obviolation To the book	4 - 4 1 1								
	4 10 10 10 10 10 10 10 10 10 10 10 10 10	edical	(Check only one)	Physician: To the bes aminer: On the basis and manners	of examination	and/or inv	occurred at the time estigation, in my opin	e, date and nion, death	i piace, an n occurred	d due to the caus at the time, date	se(s) and manr and place, an	ner as sta d due to t	ited. the cause(s)
	To tha I within 2. To tha I complet	Me	29b. Signature and title of certifier	1 0 1	-/		29c. License	number		29d	. Date signed	Month, D	lay, Year)
)			* X ahrl	/ /an	Lones	1	1 D-	139	71	4	/7/1	25	
			30. Name and ddress of persol wh	o comple ed ca se f	death (Item 2	За) (Турр, Р	Print)	/	1			400	
			Kobert L. +	faufr	ran	-Fr	ederick	me	m.	Has.	Jus	esie	k md.
	Sta		31. Date filed (Month, Day, Year)	2005 82. Regis	trar's Signatur	9							,
	Registr	ar	JUN 1 4	2005	u B	do	alles						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland		artment tificate			and M		giene Reg. No.	005	Total control	981	08
	Physici	an	1. Decedent's Name (First, Middle, Last								2. Date of De Month	ath Day	Year	r	Time of I	
	/Medic	al		Rebecca		Arms					June	3	200		338	P M
1	Examin	er	4a. Facility Name (If not institution, give Washington Count				13		Location o	10			County of De LShina	1		
	Funeral		5. Social Security Number 6. Se		ge (In yrs. Ia	ast birthday)	If Under	1 Year	If Under:		8. Date of Birt			-	(State or	Foreign
	Director		173-42-5264	□M 210 F	51	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da July 2	$^{y_{1}}_{1953}^{Y_{8}_{ar}}$	Pé	country) enna.		
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							104.1	Inside City	Limito
	daryla f eho	ō	Penna. Frankli	n		reenca									inside City 1 ∐ Yes	
	r 28e	Funeral Director	10e. Street and Number		<u> </u>	reence	10f. Zip	Code				10g. Citiz	en of What 0	Country?		/
	23e o	al D	14396 Walnut Loc	р				172	25			U.	S.A.			
	eme :	iner	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S	S. 13.	Was Deced	ent of Hi	spanic Orio	gin? (Spe	cify Yes or No Rican, etc.)		4. Race - An Black, Wh		ndian,	
36	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow ta Mudical Existin at transi Les ricitified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give	No		1 ☐ Yes 2		Specify:	,	, , , , , , , , , , , , , , , , , , , ,			White	е	
21215-0036	tural'	ed b	15. Decedent's Edi	Year or Dates:		16a. Dece	lent's Usua	Occupa	ation			16h Kin	nd of Busines	s/Industr	7/	
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212	ad with giene.	Com	12	3	3+)	Reg	ister	ed N	urse			Nu	rsing			
pul	be filed within 72 hours after death with the Marylan ital Hygiene. 9d other than "natural", or iteme 23e or 28e-1 ehow event, the Medical Exact after the rediffied at	Be	17. Father's Name (First, Middle, Last)	1							(First, Middle,	Maiden S	Sumame)			
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Maryland	traur		19a. Informant's Name/Relationship (T		and		-				Route Number	-			fe)	
ē,	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic	:	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nam	ne of			ate		cation - City o		State	
Ë	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State)	9	hsbur	-	,		6/6/	05	Smit	hsburg	z. Mc	d.	
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licens	608	- <	22	. Name and	d Addres	s of Facilit	y on F	uneral			, -		
_	20 E E 9		H. Marlin &	immein	~~0	4	5 S. (Carl	isle	St.	Greenca	stle		1722	25	
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each l	d the death. line.	. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rest,		Inte	proximate erval Betw set and De	een
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Jut	du	1 al	HR	un	a to	mo	a					
п	Examiner		ſ	Due to (or as	s a consequ	ence of):	15 6			1	to	P				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ue to (or as	s a cons	no :	13 (A	61 6	4	du	10	Cou	in 6 d	12		
V	cuted nd ransit	Examiner	that initiated events	c												
90	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	s a consequ	ence of);										
8760,	physic	Physician/Medical		d												
Box 6	death certificate e attending phys d for use as the	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of de	elivery		
	death e atter d for u	clar	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a			Ectopic pre Other (spe						Month	Day	Ϋ́	9ar
P.O.	at the de by the stached	hys	9 Unknown	9Ll Unknown												
	requires that the een signed by th nould be detache	by	Part II. Other significant conditions co	Intributing to death I	but not resul	lting in the u	nderlying ca	ause give	n in Part I.				se contribute			
ord	w requir been si should	eted	- Dichet en l	121114	cus						101	es 2	2No 3∐F	robably	4 🗆 Ur	iknown
Vital Records,	e la has	Completed	hypertens	2021							24a. Was autop		24b. Were a prior to death?	complet	indings av	vailable use of
al	icien: The l certificate ha ector, page ?	e Co	05 111-1-1-1-1-1								1 ☐ Yes	2 2 No	1 Ye		No	
Ş		To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospitat: 1 Inpati	ient 2 🗆 E	R/Outpatien	t 3 🗆 DO	Δ Othe	\r		<i>(Check only o</i> ne 5 ☐ Resid		Other (So	ooiful		
o c	ding Phye th. After this funeral di		27. Manner of Death	28a. Date of Inju	ury	28b. Time of		Bc. Injury Work	at		8d. Describe h			BCIIY)		
Sior	Attending it death. octor: After by the fune	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigation	June 2,		7:00	PM		/es 2 🗚	46	Falla	t ho	me			
Division	l or Atten efter deat Director: I in by the	ertiflcatlon;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	itury - At hor	me, farm, str	eet, factory,	, office		2	28f. Location (S City or Tow 4376	Street and vn, State)	Number or F	Rou	ute Numbe	er,
	pitel ours e surs e serei D	O	29a. Certifier 1 Certifying Phy	10	me	Jades doot				1	4386	Casi	412 6	17/1	1722	5
٠	To the Hoepitel or Attent within 24 hours effer deat! To the Funerel Director: completely filled in by the	edical	(Check only one)	iner: On the basis of and manner si	of examination	on and/or in	estigation,	in my op	e, date and pinion, deat	th occurre	ed at the time,	date and	and manner a place, and du	is stated.	cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Mor	nth, Day,	Year)	
}			Silwal 1	1. 4) 0	40 7	TT M	JE	0	-20	62		Jun	e 4,	20	05	-
	6		30. Name and address of person who c	ompleted cause of	death (Item	23a) (Type,	Print)		- /	1	teno C	seisi	Ewan	MI		
			31. Date filed (Month, Day, Year)) 1 HO	rar's Signati	(T)	14,00	(G	ICHL	nd	1 enoc	0 190	1	217	242	
	Sta Registr		JUN 1 4 2	005	rar s signati	b A	realis	,								
		2		BULL	100	- /-/										

				partment of Health and Nertificate of Death	Mental Hygie	0000	309
	Division		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time o	of Death
	Physici /Medio		GRETA ANN ATWELL		JUNE 8,2	Day Year 2005 3:00	Δ Μ
}	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			2225 PINEFIELD WAY	WALDORF		CHARLES	
K	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Ye	9. Birthplace (State Country)	or Foreign
	Director		572-40-4186 1 M ZYF 73 Yrs. Usual Residence of Decedent		MAR.14,1	1932 ARK.	
	land ow		10a. State 10b. County 10c. City, Town or	Location		10d. Inside C	City Limits
	Man,	ğ	MARYLAND CHARLES	WALDORF		1 🗌 Yes	s ACMO
	r 28g	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
	th with	Funeral Director	2225 PINEFIELD WAY	20601	11	J.S.A.	
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,	
92	or It		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, etc.	
8	urel',	d b	3 X Widowed 4 Divorced Year or Dates:			Specify: WHITE	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show out, the Medical Examiner must be restified at	Completed by	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	king 16t	o. Kind of Business/Industry	
12	withii ene. then	щC	Elementary/Secondary (0-12) College (1-4or 5+)	OMPTROLLER		C COVE	
	filled Hygi other		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	S.GOVT.	
Maryland	ild be lental ked o	To Be	WALTER JAMES PETERSEN		LIZABETH		
ary	shou and N s mai	je-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rur			
	and 2 alth a 127 is		JAMES ATWELL, SR SON 2225	PINEFIELD WAy	WALDORF	,MD.20601	
ore	of He of He litem		20a. Method of Disposition 20b. Place of Discemetery, co	position (Name of ematory or other place)		. Location - City or Town, State	
<u>Ĕ</u>	Pag ment ent: b		'4 □ Donation 5 □ Other (Specify) METROPOLI	TAN CREMATORY 6-	-10-05 A	LEX. VA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be multiled at ance.		21. Signature of Funeral Service Licensee M()()4/9	22. Name and Address of Facility			
ш	205 2 3			RAYMOND FUNERAL LA PLATA, MARYLAN	ND 20646	, P.A.	
			23a, Part1. Enter the disease, or complications that aused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximatinterval Bet	tween
	Physician		Immediate Cause (Final disease or condition a.	2		Onset and	Death
	/Medical Examiner		resulting in death) Due to (or per a) consequence of)	notic Caratrova	0		
	*	-	Sequentially list conditions, if any, leading to immediate b. Due to [or as a consequence of]:	volve argiora	scular d	islase	
11	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
<u>V</u>	execu n and ial-tra	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,<	ficate be executed physician and s the burial-transit	dicai	L _d			1	
9	tificat ig phy as th	ledi					1915-00 Hz
Вох	es that the death certifigned by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery	
	e dea he att	sicie	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day	Year
o O	at the	Phy	3 - OUKIOMII				
ŝ	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of c	_
0	w require been sig should b	eted			1 L Yes	2 No 3 Probably 4 A	Jnknown
Records,	e law has b	ompleted			24a. Was an autopsy	24b. Were autopsy findings prior to completion of c	available ause of
_	ate pag	So.			performed 1 ☐ Yes 2 ☐		
Vita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	Othors	h (Check only one)		
ō	Phys rahdi	10	1 Yes 2 FR/Outpatient 2 FR/Outpatient 2.	All Nursing Ho	me 5 Residence 28d. Describe how in	6 Other (Specify)	
0	ding P th. After funer	tion	1 → Atural 5 Pending (Month, Day Year) Injury 2 Accident investigation		ZBG. Describe now ii	ijury occurred	
Division	Attendir death.	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Street	and Number or Rural Route Num	ber.
S	a afte		4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, St	ate)	
	To the Hospitel or Attending Physicien: within 24 hours after death and To the Funerel Director: After this certifical completely filled in by the funeral director,	aic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	e(s) and manner as stated.	
	the H in 24 the Fi plete	edical	(Check only 2 Medical Examiner: On the basis of examination and/or and granner stated.	nvestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s	;)
	To To Con	Σ	29b. Signature and title of certifier	29c. License number	29d. I	Date/signed (Month, Day, Year)	
	5		1 HH Un	1) 225 74	4	1/8/05	
	4		30. Name and address of person who collections of death (Item 23a) (Type	Print)	2h 2n	2 hald - 0 1	DN
	7		R, Tim oth y Pace M. D. 12070 Old 31. Date filed (Month, Dal, Year) 32. Maistrar's Signature	Line Center, S	ne. W	1, NULLAOY+, M	In
the state of	Sta Registra		JUN 1 4 2005	port .		-30	

7			1 - State of Ma		partment of Fertificate of			Comment of the Comment	5	9810
			Decedent's Name (First, Middle, Last)		ortinoato or		2. Date of Death		3	3. Time of Death
_	Physici		Vernon Lorenzo Barrott				Month		Year	940 PM
	/Medie Examir		4a. Facility Name (If not institution, give street and number)		4b. Gity, Town, o	or Location of Death		4c. County o		
			Citizens Nursing Home		Hours C	de Grace		Ho	artord	,
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/04/19	Year)	9. Birthplace Country)	e (State or Foreign
	Director	ļ	580-01-0496 Usual Residence of Decedent	76 Yrs			11/04/19	928 \	/irgin	Islands
	fand ow		10a. State 10b. County	10c. City, Town or	Location				10d.	Inside City Limits
	Mary F sh	Ď	MD Harford		Aberdeer	n			i	Y⊡Yes 2□No
	with the Maryland a or 28e-f show	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	hat Country	?
	15 wil		713 Edmund Street		2100	01		U.S.A.		
	r dea	Funerai	11. Marital Status 12. Was Decedent E- Armed Forces?	ver in U.S. 1	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spe an, Mexican, Puerto F	city Yes or No- Rican, etc.)		- American , White, etc.	
	36 safte	by Fi	1 ☐ Never Married 2 CXMarried 175 Yes 2 ☐ No 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates! 0)	1 ☐ Yes 🏖 No	Specify:		Specify:	Blac	k
	hour hour		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 10	16a. De	cedent's Usual Occup	pation	1	6b. Kind of Bus	iness/Indust	try
	oin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(G	ive kind of work done e. DO NOT use retired	during most of workird)	ng i	00. 110 01 000		.,
	d with giene	E O	12 0		Military		Ţ	J.S. Gov	<i>y</i> ernme	ent
	al Hy	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	aiden Sumame)	
	Vial	2	Joseph Emanuel Barrott			Eseline V	7annessa	Bastia	n	
	Maryland 21215-0036 d 2 should be filed within 72 hours all this and Mental Hygiens 77 is marked other then "natural, or traumatic event, the Medical Evanni traumatic event, the Medical Evanni		19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street					de)
	e, N 1 and 1 ealth 1 ealth 1 ealth 1 her t		Lina Barrott (Wife) 20a. Method of Disposition	No. of Concession, Name of Street, or other Designation, Name of Stree	BEdmund Stapposition (Name of					Ctata
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other then *natural; or Items 28a or 28e-1 show eny injury or other traumatic event, the Medical Examiner must be notified at once.		1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, c	crematory or other plac	ce)	4	0c. Location - C		State
5	Itin		` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Mem. Garde		/2005 Ak			
	Depariment of the control of the con		Mara C. Beller	ian	22. Name and Addre Carring—Cai 333 S. Parl	rgo Funerl ke Street,	Home, I Aberdee	P.A. en, MD 2	21001	
			23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	he death. Do not	enter the mode of dyin	ng, such as cardine of	respiratory arres	st,	Int	proximate erval Between iset and Death
	Physician	26.	Immediate Cause (Final disease or condition resulting in death)	AL	CHRILLE?	(Sas			0,	isot and Death
	/Medical Examiner		Due to (or as a	consequence of):						
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):					_	
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						- 1	
	60, be executed lician and burial-transit	Exa		consequence of):						
	8760, cate be ex physician the buria	dical	d							
	K 68	Med	IF FEMALE:							
	Box eath cert attending for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Fetal death	3 □Ectopic pregnancy	,		23d. Date Mont	of delivery h Day	y Year
	P.O. I	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti 9 ☐ Unknown 9 ☐ Unknown	me of death	5 ☐ Other (specify) _					
	ds, P.O. Box 6 ires that the death certific signed by the attending to		Part II. Other significant conditions contributing to death but	not resulting in the	e underlying cause giv	en in Part I.	23e. Did toba	cco use contrib	oute to the ca	ause of death?
	Vital Records, P.O. Box 6 sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	d by					1 🗆 Yes	2 □ No 3	Probably	4 Unknown
5	cord w requir s been si	Completed					24a. Was an	24b. W	ere autopsy	findings available
2	Re Ithe Ite has age 2	E O					autopsy perform	ed? de	ath?	etion of cause of No
3	Vital Re(ician: The lav certilicate has rector, page 2	BeC	25. Was case referred to medical			26. Place of Death			1103 2	
tt, Vernor	of Vita Physician: this certific ral director,	2	examiner? 1 Yes 2 Hospital: 1 Inpatient	t 2 ER/Outpat	tient 3 DOA Oth	er: 4 Nursing Hom	ne 5 🗆 Residen	ce 6 Other	(Specify)	
ち	Ing Pl	on:	27. Manner of Death ✓ Natural 5 □ Pending 28a. Date of Injury (Month, Day	Year) 28b. Time Injur	y Wor	k?	8d. Describe how	injury occurred	t	
-	Sio	cati	2 Accident investigation	111		Yes 2 □ No	06 1 104	-4		
B	Division of Attending after death. Director: After din by the fune	Certification:	4 Homicide determined 288. Place of Injur	(Specify)	street, factory, office	2	8f. Location (Stre City or Town,	State)	or Hurai Ho	oute Number,
*	Division of Vital Rewithin 44 hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or	eath occurred at the tin	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	ise(s) and mani e and place, an	ner as stated	i. cause(s)
-	o the ithin somple	Med	one) and manner state 29b. Signature and title of coefficier	,u.	29c. Licens	e number	290	d. Date signed (Month, Day	, Year)
	⊢ ≤ ⊢ ō		Man an Branch	18 11	1	147801	7	61	9/15	_
	1 M		30. Name and address of person who completed cause of dea	ath (Item 23a) (Tyr	pe, Print)	1 di	- /	20/	111	
	121		THOMAS GONDO 314	5. UK,	ON AVA	& All	I NO K	THY!	141	2/078
	Sta		31. Date filed (Month, Day, Year) 32. Jegistrar	's Signature	hack i	/		/	/	-
	Registr	al	MALIA	I SS K	THE STATE OF THE S					

		1	For State Registrer		of Marylar		artment rtificate				ental Hy	/giene) 5	198	311
_	Physicia		Decedent's Name (First, Middle HENRIETTA	, Last)	BERI	RIN					2. Date of D Month MAY	eath 25	y 20)05	3. Time o	of Death 5 a M
	/Medica Examine		4a. Facility Name (If not institution HCR MANOR C		ımber)		4b. City, T		Location of			P			CORGES	
	Funeral Director		5. Social Security Number 579-24-5263 Usual Residence of Decedent	6. Sex 1 □ M 2 X F		last birthday) 37 Yrs.	If Under 1 Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D OCT	irth lay Year) L6, 1	.917		RGIA	or Foreign
	filed within 72 hours after death with the Maryland Hygiene. thysiene. ther then "naturel", or items 23e or 28e-f show int. The Madical Examera must be multiled at	Funeral Director	10a. State 10b. County	E GEORGES		ity, Town or Lo						10g. Cit	izen of W	/hat Cou		City Limits 3 2 □ No
	ath with	ralDi	7105 QUARRY CO					0743				U.	S.	Α.		
9036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumatic event, the Medical Examinating the multilled at	2	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed F	2 ₫ No ive		Was Decede If Yes, speci		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	0-		k, White,	can Indian, etc. ACK	
Maryland 21215-0036	within 72 h	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed)) (1-4or 5+)	16a. Deced (Give life.	dent's Usual kind of work DO NOT use	Occupa k done di e retired)	tion uring mos	t of workir	ng			siness/In		
land?	2 should be filed within and Menta Hygiene. is marked other then eumatic event, ItaM.	To Be C	12th 17. Father's Name (First, Middle, WILLIAMS EVANS	_ast)		DERICT	101111				(First, Middle	e, Maiden			ОТЦ	
	1 and 2 sho Health and N Hem 27 is ma		19a. Informant's Name/Relationsl BARBARA A. KEMP		NIECE)	710	5 QUA	RRY		CAP	Route Numb	IEIGH	TS,	MD.	2074	3
Baltimore	Page nent o nt: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	ecify)	State	Place of Dispo cemetery, crer Ly West	natory or ott End (her place Ceme	tery	0 6- 0	ate 94-05	Was	hing	ton,	Ga.	
a a	permit. Departn Importe eny inju		21. Signature of Funeral Service I	, Bacy	m. CC	361 22	3447	l4th	STRI	EET,	BAC	ASHI	NERA	h, HS	ME 200	18.
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a ACU	caused the dea each line. JTE MYOC (or as a consec	CARDIAL				cardiac o	r respiratory a	arrest,			Approxima Interval Be Onset and HRS	tween
8760.	cate be executed physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ATH	IEROSCLE (or as a consec (or as a consec	EROTIC quence of):	CARDI	OVAS	CULAI	R DIS	SEASE				YRS	
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	w requires that been signed be should be deta	ò	Part II. Other significant conditio	ns contributing to c	death but not res	sulting in the u	nderlying ca	use give	n in Part I.				_		ne cause of pably 4	
G- (At (117 Mb)	The law re- ate has bee	Completed											a b	rior to cor eath?	psy findings mpletion of a	available cause of
Z. Sita	Physicien: The this certilicate haral director, page		25. Was case referred to medical examiner?	Hospital:	Inpatient 2] ER/Outpatien	nt 3 🗆 DO/	Other	r		(Check only		e Cothe	· /C===:4		
lation	Attending Physic death. ector: After this by the tuneral di	- 1	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		c. Injury Work	4.5	2	ne 5 Res				y)	
Paris	itel or Atten us after deat rel Director: lled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 28e. Plac build	e of Injury - At h ling, etc. (Speci	fy)					8f. Location (City or To	wn, State)			nber,
	To the Hospitel of within 24 hours af To the Funerel D completely tilled in	edical	29a. Certifier (Check only one) Certifyin 2 Medical (Physician: To the exeminer: On the band man	e best of my knopasis of examinations stated.	owledge, death ation and/or in	vestigation,	in my opi	inion, deal	d place, a th occurre	nd due to the	cause(s) , date and	and mar i place, a	nner as st nd due to	tated. the cause(s	5)
	To the Ho		29b. Signature and tille of certifier	1 l.	~				2261					(Month, 200	Day, Year) 5	
il	(5)		30. Name and address of person Richard Feldm	who completed cau	se of death (Iter	m 23a) (Type,	Print) 9500	Ann	apoli	Ls Rd	. Lan	ıham,				
- 1/	State Registra	-	31. Date filed (Month, Day, Year) JUN 0 1 2	005 See	Registrar's Sign	ature	E.									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Nathan Baxter Benson Jr.

10212

			- State Registrar				$C\epsilon$	rtificat	te of L	Death)		Rag	No.	10	120	6
1	Dhysis	ion	Decedent's Name (First, A.	iddle, Last	")							2. Date of Month	Death		Year	3. Time	
	Physici /Medi				on, Jr.							May	25	^D 2005		2:16	Ам
	Examir	ner	4a. Facility Name (If not insti	ıtion, give	street and nu	ımber)			, Town, or						y of Death		
			6900 Waker N			7 4 //	an Inna binda d		trict	He1				Princ	e Geo		
	Funeral		5. Social Security Number	6. Se	x ⊋M 2□F		rs. last birthday Yrs.	Months		Hours	Min.		Day, Y			lace (State ntry)	
	Director		577-21-4889 Usual Residence of Deceder			18	3	<u> </u>	l			May 2	2/,	1986	wash	ingto	n, DC
	lanyland show		10a. State 10b. Co			10c.	City, Town or L	ocation							1	Od. Inside (City Limits
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	r 28g	irec	10e. Street and Number					10f. Zij	p Code				10g	. Citízen of	What Cour	ntry?	
	h wit	a D	7107 Silverto	n Cou	ırt			20	0747				U	nited	Stat	es	
	dea	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Dece	dent of Hi	spanic Or	igin? (Spe	cify Yes or	No-		ce - Americ		
9	or It	F	1 ✓ Never Married 2			2+71No		1 Tes		Specify:		tiouti, oto.		Speci	ack, White,	lack	
000	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show deat Examiliser must be rediffed at	d by	3 Widowed 4 Divo		Year or L	Dates:								Speci	y. D	Lack	
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	filed y Hygie other i	S	12 17. Father's Name (First, Mic	dle, Last)			Kal.	Lroad	WOLK		er's Name	(First. Mic		Priva den Suma			
an	Mental Mental arkad o	o Be	Nathan Baxter	Bens	on. Sr	٠.			İ		n Wea						
Maryland	2 should and Men Is marka aumatic	2	19a. Informant's Name/Relat				19b. Mai	ina Addres	s (Street a				mber. C	itv or Town	, State, Zip	Code)	
N S	and 2 : salth ar n 27 Is		Dawn Clark/Mo	ther										ights		2074	7
ē,	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hyglene. itam 27 Is merkad other than "natural", or Itams 23a or 28a-f show other traumatic evant. Ite Medical Exarta natural be retified at		20a. Method of Disposition				. Place of Disp	osition (Na	me of	01	Da	ate	200	c. Location	- City or To	wn, State	
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alti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Ser	rice Licen	ee			2. Name ai						zczan	ur ra,	VIII	Inia
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			23a. Part 1. Ziter the diseas shock, or heart failure	or compl	teations that	caused the de										Approxima Interval Be	
	Physician		Immediate Cause (Final disease or condition	,	(-)	unsla		our								Onset and	
	/Medical		resulting in death)		Due to	(or as a cons											
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60,	be ex		,		200 10	(0) 43 4 60/15	equence or,										
68760,	certificate be executed nding physician and use as the burial-transit	n/Medical			d								_				
ox (n certif	/Me	IF FEMALE: 23b. Was decedent pregnan		23c. If yes, ou	tcome of preg	gnancy							23d Da	ate of delive	ND/	
ă	the atter		in the past 12 months?		1 ☐ Live I 4 ☐ Pregi	birth 2 □ Fe nant at time o		⊒Ectopic p ⊒ Other (sø								Day	Year
P.O.	the cy the achee	hysi	9 Unknown		9□ Unkn	own											
	The law requires that the death ate has been signed by the atter page 2 should be detached for t	by Physicla	Part II. Other significant cor	ditions co	ntributing to d	leath but not r	esulting in the	underlying o	cause give	n in Part I		23e. D	id tobac	co use con	tribute to th	e cause of	death?
rd	w require been sig should b	ed t										1	☐ Yes	2 12 No	3 ☐ Prob	ably 4]Unknown
000	aw requis been 2 should	plet										24a. W		24b.	Were autoprior to cor	psy findings	available
ď	The law	Completed										, p	utopsy erformed s 2 🗆	t?	death?	npietion of 2□ No	cause or
ita	ysician: The lav is certificate has director, page 2	Be	25. Was case referred to me examiner?	dical						26. Place	of Death				71		
of Vital Records,	hysic his ce	2	1 XYes 2 □ No	1	lospital: 1 🗆	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DC	Othe AC	r: 4 🗆 Nu	ırsing Hom	ne 5□R	esidenc	9 6 y th	ner (Specify) Scen	.e
П	ng P	on:	27. Manner of Death 1 □ Natural 5 □ Pe	ndina	28a. Date	of Injury th, Day Year)	28b. Time of Injury	of 2	28c. Injury Work					njury occur			
sio	tendi eath. or: A	cati	2 Accident inv	estigation uld not be	5/29	5/05	1:55	A M		′es 2 🔼				ect S			
Division	or Ati fter d Siraci in by	Certification:		ermined	28e. Place build	of Injury · At ing, etc. (Spe	home, farm, st cify)	reet, factor	y, office		2	8f. Locatio City or	n (Stree Town, S	t and Numl tate) 69 (oo BL	Route Nur	nber, LKQ V
	pital urs a arel E		CO- Continu	A.i. a. Dh.	-1-1-1-1-1	+	19 hw					Mill	Ka	Capi	tol He	eights,	MD
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funarel Diractor: After this certifica completely illied in by the funeral director,	Medical	29a. Certifier 1 ☐ Cert (Check only 2 ☑ Med	cal Exami	ner: On the b	e best of my k easis of exami iner stated.	nowledge, dea ination and/or in	n occurred vestigation	at the tim	e, date an inion, dea	id place, ai ith occurre	nd due to t d at the tin	he caus 1e, date	e(s) an'd ma and place,	anner as st and due to	ated. the cause((s)
	o the	Me	29b. Signature and title of ce	tifier	and man	mor statou.		290	c. License	number			29d.	Date signe	ed (Month, I	Day, Year)	
)	F 3 F 8		I (IN)	RP	110	1001	1 1110		OCM	Œ							
0	(E)		30. Name and address of ner	son who a	ompleted cause	se of death /It	tem 28a) (Tune	Print)					Ma	,	200		
	9		30. Name and address of per	H . t	TILA	NIN	e/	111	l Per	n St	reet	Balt	imo	re, M	aryla	nd 21	201
	Sta	ate	31. Date filed (Month, Day, Y			Registrar's Sig											
	Registi	rar	JUN 0 1	2000	Head	in s	1 for	Les .									
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			1 - For State of Maryland / Depar	tment of Health and Men	ntal Hygien	2000	19813
	Physici /Medi	cal	Roberto M Borroto	M	lay 26		3. Time of Death 2:54 A M
	Examir	ner	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Silver Spring If Under 1 Year If Under 24 Hrs. 8. t Months Days Hours Min. (Date of Birth	Montgomer 9. Birthp	y place (State or Foreign ntry)
	Director		578-72-2648		5/10/192		0a. 10d. Inside City Limits
	the Maryli 28e-f sho	ector			100.0	Citizen of What Cour	1 X Yes 2 ☐ No
ယ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or paker traumatic event. The Medical Examinar must be multiled at once.	Funeral Director		20910 as Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Rica	Yes or No- in, etc.)	ited State 14. Race - Americ Black, White,	es can Indian,
5-003	72 hours a natural, c	eted by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	X Yes 2 No Specify: Cuban "It's Usual Occupation of of work done during most of working of NOT use retired)		Specify: Wh:	ite
2121	iled within tygiene. her then nt, the We	Completed		et Server		ood Servi	ce
ylanc	ould be fi Mental I- varked ot hatic ever	To Be	Juan Borroto	18. Mother's Name (Fir	Acosta		
Baltimore, Maryland 21215-0036	tges 1 and 2 sh of Health and if item 27 is n or pither traun		Mirta Borroto - Wife 10000 E 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition commetery, crematical commeters.		02 Silve	er Spring; Location - City or To	, MD 20910 own, State
Baltin	permit. Pa Departmer Important any injury once.		A □ Donation 5 □ Other (Specify) Rock Creek 21. Signature of Funeral Service Licensee 22. N Him 118	Name and Address of Facility nes-Rinaldi Funeral BOO New Hampshire A		hington, Inc er Spring,	
2	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter to shock, or head tallue. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastrointestinal B1 Due to (or as a consequence of):	the mode of dying, such as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death 1 Day
	Examiner	iner	Sequentially list conditions b. Sepsis				l Day
8760,	cate be executed oblysician and the burial-transit	dical Examiner	cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				Years Years
O. Box 68	death certifi e attending p id for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec 4 □ Pregnant at time of death 5 □ O	ctopic pregnancy other (specify)		23d. Date of delive Month	ery Day Year
rds, P.	ires tha signed d be de	by	Part II. Other significant containons contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
al Record		Completed			24a. Was an autopsy performed? 1□ Yes 2\\\ N	prior to cor death?	psy findings available mpletion of cause of
of Vital	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpatient	26. Place of Death (Ch 3 DOA Other: 4 Nursing Home		6 ☐Other (Specify	y)
Division of	ttending P death. ctor: After t t the funera	Certification:	27. Manner of Death 1 ★ Natural 5 □ Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	Describe how inju	ary occurred	
DIX	fo the Hospital or Attending Physician: within 24 hours after deals for the Fundral Director. After this certilic completely filled in by the funeral director.	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		Location (Street a City or Town, Stai	ind Number or Rura. te)	l Route Number,
	To the Hospi within 24 hou To the Funer completely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or invessional manner stated.	ccurred at the time, date and place, and c stigation, in my opinion, death occurred at	due to the cause(s t the time, date ar	 and manner as stand place, and due to 	ated. the cause(s)
	vithin 2 To the complet	2	A. Nama3 m	29c. License number 050987	ŀ	ate signed (Month, I	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print AHWED NAWAY 83819 (PO Box)		ser n	m 208	83
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 I 2005	الما	0		-

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month **Physician** 620 PM OSEPH EVERE Mai 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year Aug. 6, 1924 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** № M 2 F Months 579-24-1277 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ent: If item 27 le marked other then "natural", or items 23a or 28a-f ehow ury or other treumetic event, the Medical Eventiller at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director Maryland Washington Smithsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28 Maple Avenue 21783 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12 Yes 2 No
If Yes, Give
Year or Dates: 1943-45 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Butcher A&P Food Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Bort Lillian Phelps ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Myers/ Daughter 28 Maple Avenue, Smithsburg, Maryland 21783 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June Date 3. 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: If any injury or Mount Zion Cemetery 2005 Methesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Lic Francis J. ddres Pisis Funeral Home Inc 500 University Blvd, West, Silver Spring, MD 20901 an Coper 23a. Part1. Enter the disease, or complications that as shock, or heart failure. List only one cause on sa Approximate Interval Between Onset and Death ised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No Yes 2 1 No 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 3□ DOA Medical Certification: To 1 Impatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No death. 2 Accident after death Director: 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide filled 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier t 2 address of person who completed cause of de ath (Item 23a) (Type, Print) m.D. COR 31. Date filed (Month, Day, Year State 3 2005 Registrar

			1 - For State Registrar	State of Ma	aryland	•	artmen rtificat			and M		jiene Reg. No.	UU)	19815)
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	h the	irec	10e. Street and Number		-1-		10f. Zip	Code				10g. Citi	zen of Wha	at Count	ry?	
	th wit	by Funeral Director	1054 Liberty Gro	ve Road					21918	3			U	.S.F	Α.	
	ams sms	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13. \	Was Deced	dent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race -	America White, e		
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Bait	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Plantment: If item 27 is marked other than "natural, or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ucen).	. Sc	Le		Pati	terso	n &	Son Fun d 2190			e, P	. A.	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	d the death.					,					Approximate Interval Between	
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ω, σ	es tha igned be del	by P	Part II. Other significant conditions of	ontributing to death b	out not result	ting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	bacco u	se contribu	ite to the	cause of death?	
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	r		30. Name and address of person who	completed cause of c	death (Item 2	23а) (Туре,	Print)	1./¥	2263 <u> </u>						-	
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			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
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	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
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	Funeral Director		235 48 7306	Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 15.	Year) Co	thplace (State or Foreign
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	with 3a or	בֿו		21911			·
	death ms 2;	nera	2116 Theodore Road	3. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	nited Stat	rican Indian,
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	6		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	<i>V</i>		
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			1 - For State Registrar	State of Maryland /	-	rtment of H		-	giene Reg. No. 005	19817
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	- 5 - 0		Dannets Rails	hall mix		OCME			MAY 25, 200	5
	ı		30. Name and address of person who	completed cause of death (Item 23a)	(Type, F	Print)				
			Pomela E. Sour			111 Penn	Stree	t Baltim	ore, Marylan	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 20	3 Registrar's Signature	dos	de				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** RANDY DUANE COLLINS MAY 24 2005 10:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-7-68 6. Sex **Funeral** Birthplace (State or Foreign Country) Min. **XX**M 2□ F 36 Months Days Hours 494-72-8059 Director Missouri Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23e or 28e-1 show other traumatic event, the Medical Examinar must be notified at Md. Montgomery Bethesda 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 7400 Wisc. 20814 Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Active Military 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mose Collins Margarette Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Collins/Wife 1900 Dill Road, #25 Barstow, CA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Marial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ö Riverside Nat Park 6/4/05 injury Riverside, Ca 21. Signatole of Funeral Service Licensee 22. Name and Address of Facility any The House of Williams Funeral Svc E. Williami 814- Upshur Street, N.W. 23a. P. nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BLAST INJURIES TO THE HEAD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause the of the by the Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran attending physician and C resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à funeral director, page 2 should be 1 ☐ Yes 255No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 □ No 1 Yes 2 🗆 No Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Xxes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 X Yes 2 □ No 6:45 PM investigation MAY 4 2005 COMBAT 2 Accident after death Diractor: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Jomicide IRAQ MOSUL Hospitel within 24 hours To the Funaral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 25 Medicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number M. D MAY 26, 2005 38593 (NC) address of person who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY 30. Name ar TAMES L. CARUSO CDR MCUSN ROCKVILLE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 31 MAY 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Pauline Virginia Coale May 9:00 p 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Residence: 2712 North East Road North East Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🖾 F 75 236-44-2868 Director West Virginia Dec. 21, 1929 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Cecil North East Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2712 North East Road 21901 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours efter ☐Yes 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White Year or Dates: Completed e filed within 72 hall Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Perry Point, Maryland Eleven Years Food Service treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H 7 Is marked ot James Stuckey Beulah Helmick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other treu Charlotte A. Lowe (Daughter) P.O. Box 79, Rising Sun, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brookview Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 06/03/05 Rising Sun, Maryland 21. Signafure of Funeral Service Licensie 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each rie. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and to (or as a consequence of) ettending physiclen Box 68760 lan/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ó in the past 12 months?
1 Yes 2 No Month Dav Year **Physic** 4☐Pregnant at time of death 5 Other (specify) P.0. the deteched 9 Unknown 9 Unknown à Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death Check onl one) examiner? Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 ☐ Yes _2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the P the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of/person who completed cause of death ec Date filed (Month, Day, Year) 32. Registrar's Sig State MAY 3 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician DENNIS LYNN DUNN \mathbf{P}^{M} MAY 23 2005 3:30 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 209 QUEEN ANNE ROAD STEVENSVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 1949 Director 551-74-2790 8, 55 HAWAII AUG. Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No Directo MD QUEEN ANNE'S STEVENSVILLE with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö r than "naturel", or Items 23a or the Medical Examiner must be 209 QUEEN ANNE ROAD 21666 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene and History and It it is marked other than "naturel, or the ury or othar traumatic event, the Mudical Examinatiny or othar traumatic event, the Mudical Examinating 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Yes. Give Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WATERMAN SEAFOOD 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MELVIN LEE DUNN ALTA SALISBURY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 QUEEN ANNE ROAD, STEVENSVILLE, MD LINDA DUNN/WIFE 21666 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER, LLC. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ^¹ 4 □Donation 5 □ Other (Specify) 05/25/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee Name and Address of Facilit poce FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final MELANUMA **Physician** Car resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical the. ned by the attending p detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ sign be 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1 Yes 2 No the Hospital or Attending Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 enesidence 6 Other (Specify) 1 🗌 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation Injury 1. Natural 1 Tyes death. nours after death nerel Director: / filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature ar 29c. License number 177706 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and JAMES CHAMBERLAIN, M.D., 130 LOVE POINT ROAD, #107, STEVENSVILLE, MD Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State of	Maryland		irtment of <i>tificate of</i>			lental	Hygie Reg	2 U L	35	19822
			Decedent's Name (I	First, Middle,	_ast)						2. Date of	f Death			3. Time of Death
	Physici /Medio		Rays	haard	D.	Dick	S				Month May		Day 2005	Year	11 · 19 P M
	Examir		4a. Facility Name (If no		rive street and numb	ber)		4b. City, Town,	or Location	on of Death	Tury	,	4c. Count	y of Death	4-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
			3200 Branc					Crest I					Prince	e Geo	rges
	Funeral		5. Social Security Num		.Sex 7. 1. 1. 2 M 2. □ F	. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Yea Months Days		ler 24 Hrs. s Min.		i, Day, Yi			lace (State or Foreign otry)
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	/land	Ì		0b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	Man a-1 sh	tor	Maryland :	Prince	Georges		Clinto	n							1 ∰Yes 2 □ No
	th the	Funeral Director	10e. Street and Number	er				10f. Zip Code				10g	. Citizen of	What Coun	itry?
	th wil	aiD	10619 Thr	ift Rd				207	35			J	Jnite	d Stat	tes
	r dea	ner	11. Marital Status		12. Was Deced Armed Ford	es?	. 13. V	Vas Decedent of Yes, specify Cu	Hispanic ban, Mexi	Origin? (Specan, Puerto	ecify Yes o Rican, etc	r No-	14. Rad Bla	ce - Americ	an Indian, etc.
36	s afte , or li	by Fu	1 ⊋Never Married 3 ☐ Widowed 4 [If Yes, Give			☐ Yes 2 No						y: Blac	
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show diseal Evaninet must be rotified at			5. Decedent's	Year or Date	es:	16a Decer	ent's Usual Occi	unation			16		Business/Inc	
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212	d within giene. ir then "	ШО	Elementary/Second		College (1-4	*OF 5+)	Di	sabled]	None		
	2 should be filed withir and Mental Hygiene. Is marked other then aumetic event, the Ms	Be C	17. Father's Name (Fin	irst, Middle, La	st)				18. Mo	ther's Name	e (First, Mi	ddle, Ma	iden Sumai	me)	
Maryland	ould be in Mental I warked o	To	Joseph 1	Dicks					Jo	oenett	a Edg	ge			
lan	2 sho and ls ma		19a. Informant's Name					g Address (Stree						_	Code)
	and ealth m 27		Joenetta		Mother	look Di		Thrift	Rd.				20735		
altimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumetic event, the Medical Examinar must be notified at		20a. Method of Dispos		☐Removal from St		ce of Dispo netery, cren	sition (Name of natory or other pl	lace)		Date	200	c. Location	- City or To	wn, State
ij	tmen tmen tant:		`4 □Donation 5	Other (Spe	cify) A			Memoria		May 3	31,200)5 La	andove	er, Mo	1.
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or othar tra QRGs.		21. Signature of Fune	eral Service Lic	Hange .	7010	55 22	Name and Add 1exande 538 Mar	ress of Fa Tboro	Pope Pike	Funer	al I	lomes,	Ma:A.	20747
			23a. Part 1 Enjer the shock, or heart for	disease, or co	emplications that cau	used the death.	Do not ent	er the mode of dy	ing, such	as cardiac	or respirato	ry arrest			Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition		a Gunsher			the hea							Onset and Death
	/Medical		resulting in death)	6		r as a conseque		10.000	V						
	Examiner		Sequentially list condi	litions,	b										
	be sit	iner	if any, leading to imme cause. Enter Underly Cause (Disease or inju-	ediate ving	Due to (or	r as a conseque	ence of):								
	ficate be executed g physician and ts the burial-transit	Examin	that initiated events resulting in death) Las		c Due to (or	r as a conseque	nce of):							-	
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68760,	ificate g phy as the	edicai			<u> </u>										
Вох	leath certif attending i for use as	Physician/M	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outco	ome of pregnand		Ectopic pregnan					23d. Da	ate of delive	ry
	requires that the death been signed by the atter hould be detached for t	sicia	in the past 12 mo 1 ☐ Yes 2 ☐ N			nt at time of dea		Other (specify)					M	onth	Day Year
P.0	at the by th	hys	9 Unknown												
	w requires that the de been signed by the should be detached	by	Part II. Other significa	ant condition	s contributing to dea	th but not result	ing in the ur	iderlying cause g	iven in Pa	irt I.			b		ne cause of death?
ecords,	equir Ben s nould	ted										1 ☐ Yes	2 250	3 Prop.	ably 4 Unknown
6 C	as z	ompleted										Mas an autopsy		prior to con	psy findings available npletion of cause of
ير		Con									DXIV	es 2		death?	2□ No
Vita	Physician: Th rithis certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:					ace of Death					
ठ	Phys this al di	. To	Yes 2 No 27. Manner of Death	0	28a. Date of		P/Outpatien 8b. Time of	3 DON	4	Nursing Ho			e 6 Oth		scene
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ivision	Attanding r death. actor: After	fica	2 Accident 3 Suicide	6 Could no determine	be 28e. Place o	f Injury - At hom		eet, factory, office		/	28f. Locati	on (Stree	at and Numi	ber or Rura	l Route Number,
2.2	after after Dira d in b	Certification:	4 Homicide	dotomini	Pack	etc. (Specify)					City o 3200 (Rown, S	state) Ave (rest H	eights MA
	To the Hospital or Attand within 24 hours after death To the Funarel Director: completely filled in by the		29a. Certifier 1[☐ Certifying	Physician: To the b	est of my know	edge, death	occurred at the	time, date	and place,	and due to	the caus	e(s) and m	anner as st	ated.
	n 24 he Fu	edicai	(Check only 2[one)	XMedical Ex	aminer: On the bas and manne	is of examination	n and/or inv	estigation, in my	opinion, c	death occurr	ed at the t	me, date	and place,	and due to	the cause(s)
	To the To the Comp	N	29b. Signature and titl	le of certifier		_			nse numbe ME	ə r		29d.	Date signe	ed (Month, I	Day, Year)
				8		1.0						Ma	y 24,	2005	
R	(1)		30. Name and address	s of person wt	o completed cause	of death (Item 2	23a) (Type,	Print)	nn Si	reet	Ra11	imo.	re Ms	arvlar	nd 21201
			31. Date filed (Month,		200 0	nintendo Cianato							, 110	~= y = C41	
	Sta Registi				005	gistrar's Signatu	Ans	de)							
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				State of M						•	•	3.
			For State Ragistrar	State of IVI	aryland	-	tificate of		ALIG IVIEL			5 19823
			Decedent's Name (First, Middle,	Last)	1		imouto or	- Douth	2.	Rag. I Date of Death	10.	3. Time of Death
	Physici		Glenn Bernar	ed Daney							Pay Ye 24 20	005 6:02 A ^M
	/Medio Examin		4a. Fecility Name (If not institution,)		4b. City, Town,	or Location o	of Death		lc. County of D	
			Laurel Region	nal Hospita	.1			Laure	1		Prin	ce George's
	Funeral				ge (In yrs. las		If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day, Yea		Birthplace (State or Foreign Country)
	Director	1	579-86-5659	IQM 2UF	37	Yrs.				ne 8, 19		Wash., DC
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	Many f she	ţ	Maryland Prince	e George's			La	urel				1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. (itizen of What	t Country?
	be filed within 72 hours after death with the Maryland lal Hygiene. d other than "natural", or Items 23e or 28e-f show event, the M. diral Examinar must be notified at	al D	3444 Andre	ew Court #	101			20	742		Unit	ed States
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Was Decedent of Yes, specify Cut	Hispanic Orig	gin? (Specify , Puerto Rica	Yes or No-	14. Race - A	American Indian, Wa iffr^{at}f can
36	s afte	y FL	1 Never Married 2 Married 3 Widowed 4 Divorced	IT Yes, Give	No		I ☐ Yes 25 No				1	American
Maryland 21215-0036	hour tural	Completed by	15. Decedent's	Year or Dates:		16a Daced	lant's Heural Occur	nation		16h	Kind of Busine	
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212	d with giene. r tha	mo	Elementary/Secondary (0-12)	College (1-4or	5+)		ntertain				Self-	Employed
פָ	othe vent,	BeC	17. Father's Name (First, Middle, La	est)				18. Mothe	r's Name (Fi	rst, Middle, Maid	n Sumame)	
/lai	uld b Ments prked	ToE	Bern	nard Dancy						Alvera I	Davis	
lan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or Items 23e or 28e-f show early rightry or other traumatic event, the Midical Examination and be notified at ODGs.		19a. Informant's Name/Relationship							oute Number, City		te, Zip Code)
	and Health m 27 her tr		Alvera D. Dano	cy - Mother						DC 2002		T. 01
Baltimore,	ges 1 If of F If ite or of		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3	☐Removal from State	cem	netery, cren	sition (Name of natory or other pla	ace)	Date	20c.	Location - City	or Town, State
ţ	t. Pa rtmen rtant; rjury		'4 □Donation 5 □Other (Spe	/	Harm		lemorial	1808				ver, MD
Bal	permi Depa Impo eny is		21. Signature of Funeral Service Lie	AT. 1	TI		. Name and Addr			art Fune		
			23a. Part . Enter the disease, or co shock, or heart failure. List or	Olluboux omplications that cause	d the death.					E. Wash	, DC	20019 Approximate
	-		shock, or heart failure. List or Immediate Jause (Final							,,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		monary a consequer		rtensio	n				-
b	Examiner			CHE								
		Jer	Sequentially list conditions, if any, leading to immediate	0.	a consequer	nce of):						
	icuted nd transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С	al Fai							<u> </u>
,092	ate be executed nysician and he burial-transit	EX	resulting in death) Last	Due to (or as	a consequer	nce of):						
876	cate b	dical		d				-				
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	v					20d D-14	4-11
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregnant Other (specify)	су			23d. Date of Month	Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	it time or doub	0_	Culoi (speary) _					
Δ.	s that ned b a deta	y PI	Part II. Other significant condition	s contributing to death b	out not resultin	ng in the ur	nderlying cause g	ven in Part I.		23e. Did tobacco	use contribut	te to the cause of death?
rds	quires in sign									1 🗋 Yes	2.⊡ X /∘ 3.⊏	Probably 4 Unknown
00	aw requir s been si 2 should l	Completed								24a. Was an		autopsy findings available
ž	The lay	HO								autopsy performed? 1 Yes 2 24	death	to completion of cause of h? Yes 2□ No
Vital Records,	icien: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?					26. Place		neck only one)		
oţ O	ding Physicien: The larh. h. After this certificate has funeral director, page 2	10	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpati	ent 2 EP	VOutpatien	t 3 DOA	ther: 4 🗆 Nur	rsing Home	5 Residence	6 ☐Other (S	Specify)
n o	ding Pl h. After ti funera		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28 ay Year)	Bb. Time of Injury	Wo			Describe how in	ury occurred	
Sio	Attending r death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	t he				Yes 2 1		1 (Cana		
Division	or Attendate death	Certification:	4 Homicide determin	286. Place of in	tc. (Specify)	e, farm, stre	eet, factory, office	•		City or Town, Sta		r Rural Route Number,
_	Hospitel 24 hours a Funeral I		29a. Certifier 1 Certifying	hysician: To the best	of my knowle	edge death	occurred at the t	ime date and	d place, and	due to the cause	s) and manner	r as stated
	24 hos 24 hos 5 Fun etely	edical	(Check only 2 Medical E)	aminar: On the basis of and manner st	of examination	n and/or inv	estigation, in my	opinion, deat	th occurred a	t the time, date a	nd place, and	due to the cause(s)
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of partifie				29c. Licen	ise number		29d. D	ate signed (Me	onth, Day, Year)
	> - 0		· //*/				1	MD 035	077		May 31	, 2005
11	Wi		30. Name and address of person wi	no completed cause of	death (Item 2	За) (Туре,	Print)					
A	4		Immal K Gw	thney, M.D	. 12	3 - 4	5th St.	N.E.	Wash.	, DC 20	019	
	Sta	. 9 . 6	31. Date files (Month, Pay 1995	32. Registr	rage Signatu	make.	•					
	Registr	ar	VALL 0 =	1	1							

			1 - For State of Maryland /		artment <i>tificate</i>			ind Mei	-	ene ()	05	19825
	Physicia		1. Decedent's Name (First, Middle, Last) Janice M. Elliott						Date of Death Month	Day	Year 105	3. Time of Death 7:45 P
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 3629 South Mountain Road		4b. City,		Location of	f Death	ay z	4c. Cour	nty of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthday)	If Under	1 Year	If Under 2	24 Hrs. 8.	Date of Birth		reder 9. Birthr	1CK place (State or Foreign ntry)
	Director		219−34−5290 1□ M 2X F 68 Usual Residence of Decedent	Yrs.	Months	Days	Hours	Min. D	(Month, Day, ec. 20,	1936		yland
	yland yland		10a. State 10b. County 10c. City, Tow					10d. Inside City Limits				
	e Mar	ctor	Maryland Frederick	Kn	oxvil	Le						1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number 3629 South Mountain Road		10f. Zip		- 0				of What Coul	
	Jeath ns 23	erai	11 Marital Status 12. Was Decedent Ever in U.S.	13.1	Was Deced	217 ent of Hi		gin? (Specif	y Yes or No- an, etc.)	14. R	d Sta	can Indian,
36	urs after o	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		fYes, spec 1□Yes 2			, Puerto Ric	an, etc.)	Spec	lack, White,	etc. hite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, it a Medical Extrall at most be notified at once.	Completed	(Specify only highest grade completed)	(Give	dent's Usua kind of wor DO NOT us	k done d	uring most	of working	1	6b. Kind of	Business/In	ndustry
212	d with	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Ho	omemal	cer				Ow	n Home	e
Maryland	be file ital Hy id oth event	Be	17. Father's Name (First, Middle, Last)						irst, Middle, M		ame)	
<u> 3</u>	hould d Men marke maric	ပ	Lee Reynolds 19a. Informant's Name/Relationship (Type, Print) 19	h Mailir	a Address	(Street a			lemming		m State Zii	Code
	Ith an Ith art		1.22		•				, Knoxv	•		
Baltimore,	of Hea item		20a. Method of Disposition 20b. Place compete	of Dispo		e of	-	Date	-		n - City or To	
Ē	Page ment c ant: If ury or		1 M Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Brown	svi.	lle Ce	emet	ery 6	/1/200	D5 B	rowns	ville	, Maryland
Balt	Depart Depart Mport Iny inj		21. Signature of Funeral Service License						ffer Fu			21716
	402 60		23a. Part 1. Enter the disease, or complications that caused the death. Do						. , Brun		, MD 2	Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition									Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	∋ of):								•
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	9 of):								
	cate be executed physician and the burial-transit	Examiner	that initiated events c.									17
8760,	be exe ician a burial-	E	resulting in death) Last Due to (or as a consequence	3 Of}:								
687	ficate physics the	edica	d									
Box	leath certific attending pl	M/u	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat	th 3.□	Ectopic pre	annanev					Date of deliv	. ,
	that the death ed by the atte detached for	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Other (spe					•	Month	Day Year
P.O.	that the	y Ph	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying ca	ause give	n in Part I.		23e. Did toba	acco use co	ntribute to t	he cause of death?
rds	w requires been sign should be	ed by							1 🗆 Yes	2 🗹 No	3 ☐ Prof	bably 4 Unknown
Division of Vital Records,	e far has	Completed							24a. Was an autopsy perform	ed?	prior to co death?	opsy findings available ompletion of cause of
Ita		ø	25. Was case referred to medical				26. Place	of Death (C	1 ☐ Yes 2 Check only one		1 🗆 Yes	2 No
) \	S 0 10	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/C)utpatier	nt 3 DO	A Othe	r: 4 🗆 Nu	rsing Home	5 Resider	ice 6 □C	other (Specia	fy)
o uc	ting P. After t		1 Natural 5 Pending (Month, Day Year)	Time of Injury	f 21	Bc. Injury Work	at ? /es 2 □ N		d. Describe how	v injury occ	urred	
/isic	Attendir death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, I	farm, str			63 2 🔲	-			mber or Run	al Route Number,
ā	tal or A rs after al Dire ed in by	Cert	4 Homicide determined building, etc. (Specify)						City or Town,	State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death und/or in	h occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, and th occurred	d due to the car at the time, da	use(s) and te and place	manner as s e, and due t	stated. o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		29c	License	number	٩	29	d. Date sign	ned (Month.	Day, Year)
	^			\ ~=	Dian	71	-13	J	7	7/7	1/21	
	7		30. Name and address of person who completed cause of death (Item 23a)) (Type,	String!	168	24000	2 W	11	f,	l	
	Sta Registr		31. Date filed (Month, Par Near) 1 2005 32. Resistrar's Signature	K	Special	A.B.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

			1 - For State Registrar	State of N	naryland / l		artment of the contract of the				giene Reg: No.		1982	26
	Dhusisi	200	1. Decedent's Name (First, Mide	die, Last)				-		2. Date of De Month	ath Day	/ Year	3. Time o	of Death
	Physici /Medio		William Donald							May	25	2005	6:30	РМ
4	Examir		4a. Facility Name (If not instituti	-		-	4b. City, Town,				4c.	County of Dea		
			501 Prospect				-D F	rede				Freder		
	Funeral Director		5. Social Security Number 220-54-3443 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 □ F	Age (In yrs. last bii 55	Yrs.	Months Days	Hour	s Min.	8. Date of Bir (Month, Da March	y, Year)	9.50 Te	thplace (State ountry) XAS	or Foreign
	land ow		10a. State 10b. Coun	ty	10c. City, Tow	m or Lo	cation			· · · · · · · · · · · · · · · · · · ·			10d. Inside C	City Limits
	Mary feet	Funeral Director	Maryland Fred	erick	Freder	ick							1 🗆 Yes	s 2 No
	h the	rec	10e. Street and Number 10f. Zip Code								10g. Citi:	zen of What Co	ountry?	
	th will	aiD	501 Prospect B	lvd, Apartme	nt 30-D		2	1701		Ţ	Unite	ed State	es	
	ems ems	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. V	Was Dacedent of f Yes, specify Cub	Hispanic (Origin? (Spec	ify Yes or No)-	14. Race - Ame Black, Whit		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modeal Example required at	[호	1 Never Married 2 Married 3 Widowed 4 Divorce	arried 1 Tyes 2 If Yes Give] No		I∐Yas 2∑XNo				1	Specify: Wh	,	
5-0	72 h	Completed	15. Decede (Specify only high	ent's Education lest grade completed)	16a	Deced (Give	lent's Usual Occu kind of work done	pation during m	ost of working	g	16b. Kir	nd of Business	/Industry	
121	within ine. han '	m	Elementary/Secondary (0-12)) College (1-4o	r 5+) S	heet	kind of work done 00 NOT use retire t Metal	Mecha	nic		Cor	nstruct	ion	
2	ited v Hygie ther t nt, th		12 17. Fathar's Name (First, Middle	a (ast)				18 Mo	ther's Name ((Eirst Middle	Maiden	Sumama)		
and	e d stal) Be		Flynt					ty Jon		, Maidell	Samame)		
<u></u>	d 2 should be f th and Mental I 7 is marked of traumatic ever	ြ	19a. Informant's Name/Relation	,	196	. Mailin	g Address (Stree	1			er. City or	r Town, State,	Zip Code)	
	5 5 5 E		David Flynt		13	270	01d Ann	apo1	is Rd,	Mt. A	iry,	MD 2177	ĺ	
Je,	- ± = ±		20a. Method of Disposition		cometa	f Dispos	sition (Name of natory or other pla	rce)	Da	te	20c. Lo	cation - City or	Town, State	
Ĕ	Pages nent of I int: if its try or o		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other		el	*	Cremato		5/29/	2005	Free	derick,	Maryla	and
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service	e Licensee			Name and Addr							
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that cause	ed the death. Do		-						Approxima	te
	Pnysician	90	Immediate Cause (Final		hosis	5	1 1711	0.					Interval Be Onset and	Death
	/Medical		diseasa or condition resulting in death)		is a consequence	of):	1100							
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	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.										
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68760,	physicate by side the control of the	edicai		d.										
		1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy						2	3d. Date of del	iven	
Вох	death cert e attending d for use	Physician/N	in the past 12 months?		2 Fetal death at time of death		Ectopic pregnand Other (specify) _	у			-	Month		Year
o.	at the de by the a tached	hys	9 Unknown	9□ Unknown										
g, D	es tha igned be det	by P	Part II. Other significant condi-	tions contributing to death	but not resulting in	n the un	nderlying cause gr	ven in Pa	t I.	23e. Did to	obacco us	se contribute to	the cause of	death?
ğ	w require been sig should b									1 🗆 1	Yes 2	ZNo 3□Pr	obably 4 🗆	Unknown
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<u> </u>		Con								perfo	rmed?	death?		
of Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medic examiner?						ce of Death (
of C	Physi r this c ral dire	မ	1X Yes 2 No	Hospital: 1 Inpat			3 DOA					Other (Spe	cify) at s	cene
		lon;	27. Manner of Death Natural 5 Pend		Jury 28b. 1 Jay Year) I	Time of njury	28c. Inju Wo	rk?		d. Describe f	now injury	occurred /		
Division	tten deat deat tor: , the	ertification;	3 Suicide 6 Could		njury - At home, fa	rm etre		Yes 2		ocation /	Street and	d Number or Ru	m / Pouto A/um	hor
2	i or Attenc after death Director: d in by the	ertil	4 - Homicide deter		etc. (Specify)	um, sue	et, lactory, office		20	City or Tox			ilai Houte Ivuii	ibei,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	ledical C	(Check only 2 Madica	ring Physician: To the bes at Examinar: On the basis	of examination an	e, daath	occurred at the trestigation, in my	me, date	and place, an	d due to the	cause(s) a	and manner as place, and due	stated. to the causa(s	5)
	o the lithin 2 o the mple	Med	29b. Signature and title of certif	and manner s	stated.		29c. Licens	se numbe	r		29d. Date	signed (Monti	h, Dav. Year)	
	F 3 F 8		MILIA	In/M	\		OCM							
	3	1	30. Name and address of perso	n who completed cause of	death (Item 23a)	(Type. F	Print)				riay	26, 20	103	
			S. R. 14	OGAN	/	, , , , , , ,	111 Per	ın St	reet	Baltim	ore,	Maryla	and 212	01
	Sta Registr	_	31. Date filed (Month, Day, Yea JUN 0	1 2005 32. F 3is	trar's Signature		and I							

			1- State Amend Item 26	State of Maryland per verbal,	67 ep	artment of I	lealth and l	Mental Hyg	giene 005	19827
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Robert Garwoo			4.05.7	and an art Daniel	2. Date of Dea Month May	th Day Year 27 2005	3. Time of Death 9:50 P M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give s Avalon Manor Healt 5. Social Security Number 268-30-9476 6. Sex	th Care Center	st birthday) Yrs.	Hager	S LOWN If Under 24 Hrs. Hours Min.	8. Date of Birth	Washingt	
	2	tor	Usual Residence of Decedent 10a. State 10b. County PA Frank		Town or Lo			,		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
,	3a or 28a.	ai Director	10e. Street and Number P O Box 138			10f. Zip Code	263	1	10g. Citizen of What C USA	country?
950	permit. Pages 1 and 2 should be filed within 72 hours after death with the maryland. Department of Health and Mental Hygiene. Important: If tiam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be motified at ADGE.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
-C121	within 72 hor ene. than "naturi he Medical 3	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+)	(Give life.	dent's Usual Occup be kind of work done DO NOT use retire achinist	pation during most of wo. d)	rking	16b. Kind of Business Truck mi	•
yland z	should be tiled and Mental Hygie s marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Robert G. Falcot				Dorot	thy E. Th	nompson	To Code
	s 1 and 2 sho f Health and itam 27 Is m other traum		19a. Informant's Name/Relationship (Ty). Kathleen M. Stou: 20a. Method of Disposition	ffer daughter	P ace of Disp	_	2, South		r, City or Town, State, 1, PA 1726 20c. Location - City o	1
Baltimore,	permit. Pages Department of Important: If it it any injury or o once.		1 Burial 2 Scremation 3 SR '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	emoval from State Curb	erland 2	l Valley Cro 2. Name and Addro	em. May ess of FacilityGro	ove-Bower		al Home, Inc
	Tysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death, ne cause on each line. If a c IV LO Due to yr as a conseque	Do not en	iter the mode of dy	ing, such as cardia	c or respiratory arr		Approximate Interval Between Onset and Death Chick'C
	/Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	once of):	% /	,			chronic.
	te be executed ysician and ie burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence DM	ence of):					chinc.
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of dead of the pregnant at time of the pregnant at ti	death 3	□Ectopic pregnand □ Other (specify)	ey .		23d. Date of d Month	elivery Day Year
rds, P.	w requires that t been signed by should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resul	lting in the	underlying cause g	ven in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
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	ng Physician: Th fter this certificate ineral director, pag	on; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death 1 vatural 5 Pending	Hospital: 1 Inpatient 2 E	ER/Outpatie 28b. Time Injury	of 28c. Inju	ther: 4 X Nursing I ury at ork?	_	ne) dence 6 □Other (Sp now injury occurred	pecify)
=	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, s		Yes 2□No	28f. Location (S City or Tow	Street and Number or I vn, State)	Rural Route Number,
	ha Hospital n 24 hours a he Funeral D	edical C	29a. Certifier (Check only one) 1 Gertifying Phy	sicien: To the best of my know ner: On the basis of examinati and manner stated.	vledge, dea on and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place, and du	ue to the cause(s)
)	To the within 2 To the complete	W	29b. Signature and title of certifier			000	6 2223		29d. Date signed (Mon	nth, Day, Year)
				O Mills St. H	agers	town, MD	21740		,	
a.	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	Const					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** May 27, 2005 4:30 James Victor Gingrich /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 □ F 09/29/1926 78 Colorado Director 577-34-5996 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a, State 1√2 Yes 2 □ No "natural", or items 23a or 28a-f eh olical Examiner must be notified Director North Potomac MDMontgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 14409 Coral Gables Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Modical Examines once. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Electrician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henrietta Y. Moser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14409 Coral Gables Way, North Potomac, MD 20878 Ethel Gingrich, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 05/31/2005 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Simple Tribute 22. Name and Address of Facility 21. Signature of Funeral Service Licentee Cem 1040 Rockville Pike, Rockville, Maryland 20852 Mym Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Carcinoma 3 months /Medical Due to (or as a consequence of): Examiner 4 months Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed tran and Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Lymphocytic Leukemia Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Funeral Director; After completely filled in by the funer 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MU D09470 May 28, 2005 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, MD, 10901 Connecticut Avenue, Kensington, MD 20895 31. Date filed (Month, Day, Year) MAY 3 1 2. Registrar's Signature State 2005 Registrar

			1- State of Maryland / Department of Maryland	rtment of Health and Mitificate of Death	, ,	ene	15 10	020	
	Physici	an	Decedent's Name (First, Middle, Last) Proceedings (First, Middle, Last)		2, Date of Death Month	Day Ye	3. Time		
	/Medic Examin	al	Rusty Keith Garber 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May	27 200 4c. County of E		P M	
	Lanin		8839 Crystal Fountain Road	Emmitsburg		Frede	Frederick		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign			
	Director		218-84-1792 10x1 31 Yrs. Usual Residence of Decedent		June 22,	1973 M	aryland		
	nylane show	.	10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside (-	
	he Ma	ecto	Maryland Frederick Emmit					s 2⊠No	
	with t	Dir	8839 Crystal Fountain Road	10f. Zip Code 21727	10	g. Citizen of Wha United			
	death	Funeral Director		/as Decedent of Hispanic Origin? (Sper Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - /	American Indian,		
36	s after or Its	y Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1	Yes, specify Cuban, Mexican, Puerro P ☐ Yes 2⊠ No Specify:	nican, etc.)	Specify:	White, etc. White		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Itams 23a or 28a-f show ant. The Modical Exempler coust by modified at	ed by	3 Wildowed 4 Divorced Year or Dates:	ent's Usual Occupation	1	6b. Kind of Busine			
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	ed witi ygjene yer tha t, the	Completed	12	river		Truck	ing		
and	htal H	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		,			
Baltimore, Maryland	should nd Mei marke matic	To	Ricky Lycurtis Garber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Roberta Address (Street and Number or Rural			te Zin Code)		
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ore,	es 1 a of Hear fitam r othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crema	ition (Name of Date)	ate 20	Oc. Location - City			
Ē	Pag tment tant: I		`4 □Donation 5 □Other (Specify) Utica Cem		od š	Utica,	Maryland		
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any njury or other traumatic event. The Modical Exemples 1, ust be notified at 900s.			Name and Address of Facility St E. Main Street	tauffer Thurmont				
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O. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E E E E E E E E E	Ectopic pregnancy Other (specify)		23d. Date of Month		Year	
rds, P	es tha	ρ	Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.		cco use contribut	e to the cause of Probably 4		
Record	The law requir ate has been si page 2 should	Completed			24a. Was an autopsy performe	prior deatl		available cause of	
Vital		BeC	25. Was case referred to medical examiner?	26. Place of Death		No 1 1	2010		
Division of \	ding Phys h. After this funeral di	2	1 Yes 2 No		Residented Residented		Specify)		
Divis	al or Attandi s after death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	it, factory, office	8f. Location (Stre City or Town,	et and Number of State)	r Rural Route Nur	nber,	
	To the Hospital or within 24 hours afte To the Funaral Dir. completely filled in 1	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the best of the best	stigation, in my opinion, death occurre	d at the time, date	e and place, and	due to the cause(s)	
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	29c. License number		I. Date signed (M			
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	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	10146 26 1000 51- 1	Evzelo	7150	4021	701	
:	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 2005	and the		,-,			

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				State of Maryland / Depa	artment of Health and M rtificate of Death		2005	10830
			1 - State Registrar	Cei	funcate of Death	2. Date of Death	g. Noire UUU	1 7 0 3 0
1	Physicia	an	Decedent's Name (First, Middle, Last)			Month	Day Year	3. Time of Death
1	/Medic		Robert 4a. Facility Name (If not institution, give st.	J. Gilch	rist 4b. City, Town, or Location of Death	May 25,	2005 4c. County of Death	10:45P ^M
	Examin				Elkton		Cecil	
	Funeral		Sunbridge Care & 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign
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	P		Usual Residence of Decedent	100.7				
	arytar show	<u>_</u>	10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits 1 ☐ Yes 2/☐/No
	he M 8a-f	Director	Delaware New Ca	stle Bear			0.00	
	with t		10e. Street and Number		10f. Zip Code		g. Citizen of What Cour	
	eath	Funeral	4 Reyburn Court	2. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ocify Yes or No-	nited Sta 14. Race - Americ	tes
	ter d	Ę	1 Never Married 2 Married	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
98	urs al	Ď	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	1 ☐ Yes 2√☐ No Specify:		Specify: Wh	ite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show iteal Examiner must be notified at	Completed	15. Decedent's Educa (Specify only highest grade	ation 16a. Dece	dent's Usual Occupation kind of work done during most of worki	1	6b. Kind of Business/In-	dustry
21	within and the series of the s	lg l	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	''g		
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<u>₹</u>	should be nd Mental marked o	2	Robert Gilchr		Lurene			
Maryland	C1 00 .00 E5		19a. Informant's Name/Relationship (Type		ng Address (Street and Number or Rura		City or Town, State, Zip	
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ğ	or of or		1 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State Gracela	wn Memorial 5/ ery		New Castl	
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	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events c.	Due to (or as a consequence of):	1	6	1)	17
>	and trans	Examiner	that initiated events c. resulting in death) Last	Chr Conges	hve Heart 7c	June	/	oyens-
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Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year
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of Vital Records,	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
<u>></u>	Physician: r this certifica ral director, i	To	1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier		me 5 🗆 Resider	nce 6 Other (Specif	y)
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Division	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	City or Town,	eet and Number or Rura State)	i Houte Number,
ш	pital ours a eral I filled		29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge, deat	h occurred at the time, date and place :	and due to the cau	use(s) and manner as s	tated
	24 hos 24 hos Fun etely	Medical		er: On the basis of examination and/or in and manner stated.				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	1:0,-	29c. License number	29	d. Date signed (Month,	Day, Year)
			parge tild	1.10421	222307	1	May 26,	2005
	\ 0		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type,	Print)		1- ^	2102
_	6		JAYANTILALK	FATELMY 1235	ingerly Ave,	E-LK7	OH, YND	21721-
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signature				
	Registi	rar	MAY 3 1 2005	Die Ir fips				

Registrar DHMH 17 Rev 1/2001

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The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

28e-f show

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LOW North Write street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert

31. Date filed (Month, Day, Year)

JUN 0 1 2005

Hoesch

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 30, Year **Physician** William Hall Sr. Α. 2:51 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Prince George's Ft. Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. November 12, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year) 1 XXM 2□ F 579-36-3424 75 Yrs. Washington, DC ~1929 Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event. Its Nexical Example, must be a writing all 1 ☐ Yes 2XX No Director Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6910 Grenada Avenue 20745 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1xXYes 2□No 1948— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 27 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes ¾√ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Technical Coordinator Stewart Petroleum Co. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental H Allan L. Hall ဥ Edith A. Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Robert Hall / Son 37315 Fast Spicer Drive Mechanicsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages , <u>=</u> 1xxBurial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or Maryland Veterans Cemetery June 3, 2005 Cheltenham, Maryland 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home P.A. neral Service Licenses 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. The five disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SUCCE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a considerent of Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE use (23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ρ in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ed bluods 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed 21 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2√√√√√√√√√√ Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 XXX tural 5 Pending s after death. 1 🗌 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of prifier 29c License number 20 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rd. Ft Washington aroline (aine Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 1 2005 Registrar

			1 - For State Registrar	State of Mar	yland / Dep		lealth and M	lental Hyg	iene _{eg. No.} 2005	19833	
	Physici /Medic		Decedent's Name (First, Middle, Last) Vivien Katherine Hal					2. Date of Deat Month May 29, 2	Day Year	3. Time of Death	
	Examin		4a. Facility Name (If not institution, give sacred Heart Home			Hyattsvi			4c. County of Death Prince Georges		
	Funeral Director		5. Social Security Number 6. Sep 578-09-3656 Usual Residence of Decedent	7. Age (In yrs. last birthday Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 5, 1	Year) Co	hplace (State or Foreign untry) ington, DC	
	e Maryland ta-f ehow	ctor	10a. State 10b. County MD Prince Geo		Oc. City, Town or L Hyattsvill					10d. Inside City Limits 1 ☐ Yes 2 No	
	3a or 26	Il Director	10e. Street and Number 5805 Queens Chapel Rd.			10f. Zip Code 20782			0g. Citizen of What Co USA	untry?	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f show aumatic event, the Maritcal Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: White	e, etc.	
215-0	ithin 72 hou ne. nan "nature Medical E	Completed	15. Decedent's Edu (Specify only highest grade		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Business/	ndustry	
_	m = 0 5	To Be Cor	17. Father's Name (First, Middle, Last) Levi V. Cox		Clerk		18. Mother's Nam	e (First, Middle, M			
Mary	Ith and M Ith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Ty Fr. Thomas Michael Hal			ing Address (Street		89,000	City or Town, State, 2	lip Code)	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or gaher traumatic evonce.		20a. Method of Disposition 1	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of amatory or other places) sh Cemetery	ca)	Date	20c. Location - City or York, ME	Town, State	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License		F.	22. Name and Addre	ss of Facility ollins Fune:	ral Home,		20901	
	Pnysician /Medical		23a. Part T. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line. a. Stroke Due to (or as a c		nter the mode of dyir	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
	Examiner	her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Atrial Fibr	ilation						
	rate be executed hysician and the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o							
O. Box 68	The law requires that the death certificate the has been signed by the attending phy bage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic pregnancy	,		23d. Date of deli Month	very Day Year	
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions cor	ntributing to death but r	not resulting in the	underlying cause giv	en in Part I.		pacco use contribute to		
		Completed	Seizure Disorders					24a. Was ar autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of	
Vitai	siclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	lospital:		oth Oth	or	h (Check only on			
Division of	ng Phys fter this neral di	ation: To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Time	of 28c. Injur Wor	y at		nce 6 □Other (Spec w injury occurred	ify)	
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, s (Specify)	treet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru s, State)	ral Route Number,	
	he Kospi n 24 hou ne Funer pletely fill	Medical	29a. Certifier 1 X Certifying Physical Check only one) 2 Medical Examination	sicien: To the best of a ner: On the basis of ex and manner state	camination and/or is	th occurred at the tir nvestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)	
	1	Ň	29b. Signature and title of certifier			29c. Licens D 5152		29	9d. Date signed (Month May 30, 2005		
	φ		30. Name and address of person who co			•			,		
	Sta Registr		Bahram Pishdad, M.D. 31. Date filed (Month, Day, Year) MAY 3 1 200		nern Ave. #		ngton, DC 20	0032			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May 22,2005 **Physician** 10:50AM **JOHNSON** JOHN HENRY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Silver

If Under 1 Year

Months Days Hours Min. Jan. (Month, Day, Year)

Jan. 5,1939 3608 Kayson St 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral Ж**] м 2□ F Yrs. 66 Director 215-36-3370 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Is marked other then "naturel", or items 23e or 28a-1 show treumatic event, the Medical Exactinar must be notified at 1 Yes 2 No Director Silver Spring Montgomery MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 U.S.A. 3608 Kayson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Goodwill Industry Stock Clerk 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown should be fit and Mental H Be Sr Johnson Kenneth 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or othey treum 3608 Kayson St Silver Spring, MD 20906 Mary N. Johnson- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/28/2005 Alexandria, VA Matro Fnrl Svcs 4 □ Qonation 5 □ Other (Specify) Signature of Funeral Sovice Licens 22. Name and Address of Facility Snowden Funeral Home, P.A 246 N. Washington St Rockville, MD20850 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pronary disease or condition resulting in death) dr years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 XYes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No has certificate Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 (es 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel E 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mau 22, 2005 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Pike, G-100, Rockville, MD 20852 Katricia Vay Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Sillmon lears 29 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner legional Medical Center
of 6. Sex 7. Age (In yrs. last birthday) Wicomico Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 230-60-9802 100 M 20 F Months Days Hours Min. Yrs. 61 Director Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Items 23a or 28a-f show HCCOMack Greenbackv 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗹 No Specify: Specify: White If Yes, Give Year or Dates: the Medical Exam 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FoodS lyson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be flik tment of Health and Mental H; tent: If item 27 Is marked oth Be Killmon Hattle traumatic wife 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2198 pinnaker naoman si IImon item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Hingortent: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenbackville Cemetery 6-1-05 Greenbackville * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility POBOX 278 Temperanceville VA 23442 Fox Funeral Home ames 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine hysician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 2 410 1 ☐ Yes Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 🗌 No this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Funerel 1 Cartying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as some 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the and title of 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur 5/31/05 H50497 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 100 E CAYOU SALISBUN Andle

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0

1 2005

Killmon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryland / Department of Health and M	lental Hygieņ	enns 19836
			Registrar 1. Decedent's Name (First, Middle, Las	Certificate of Death	Reg. N	3. Time of Death
	Physici		Willia	teary ankford	Month D	2 05 9:12 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number) 4b. City, Town, or Location of Death		c. County of Death
			Hartley Hall	NUTSING Home POCOMOKE	L	Norcester
	Funeral		5. Social Security Number 6. S	7. Age Im yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	<i>D</i>	05-05-	18 04;
	nylane show	_	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	8e-f	acto	INA WORCE	ster rocomoke City	T	1 Tyes 2 TNo
	with t	ğ	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	72 hours after death with the Maryland neture!', or items 23a or 28e-f show dice Examirer must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
92	after dea or items	y Fui	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No 1 ☐ Yes, Give 1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, etc. Specify: Q
5-0036	hours turel',	Completed by	3 Widowed 4 ☐ Divorced 15. Decedent's Ec	Year or Dates:	106	Kind of Business/Industry
15	in 72 n *ne n Jic	plete	(Specify only highest gra	de completed) (Give kind of work done during most of work) life. DO NOT use retired)	ing 160.	Kind of business/industry
2121	filed within Hygiene. Ither than "	Com	7th grade	College (1-40r5+) IFUCK-driver	Go	Ida Pride Parts
pu	be file ital Hy id oth event	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	an Sumame)
Maryland	should be to and Mental I marked or umatic eve	10	19a. Informant' Name/Relationship (7	ype, Print) 19b. Mailing Address (Street and Number or Rura	QUAGE CONTROLLE	HYELS
Ma	nd 2 s lith an 27 is u		Twee Packs	(daughter) 1970 Colorera Rd Po	Comale I	City and 2/1851
Je,	of Heal		20a. Method of Disposition	compton, promoton, or other plans)	Date 20c.	Location - City or Town, State
<u>m</u>	Page ment ent: If ury o		1 D Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		-05 Po	comoko md
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Importent: If item 27 is marked other than "neture!", or items 23a or 28e-1 show any injury or other treumatic event, the Marital Examiner mat he notified an once.		21. Signature of Funeral Servin	22. Name and Address of Facility &	wie Sm	ith funcral Home
	22200		23a. Part1 Enter the disease, or com-	plications that caused the death. Do not enter the mode of dying, such as cardiac cone cause on each line.	or respiratory arrest.	Approximate
	Pnysician		Immediate Cause (Final	C		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):		
	Examiner	L	Sequentially list conditions,	b		
	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
Ć,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequence of):		
68760,	ficate be executed physician and s the burial-transit	edlcal		d		
	= O 0	Med	IF FEMALE:	On the second of the second		
Вох	that the death certiff ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
o.	0 0 0	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		
s, P.	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ord	w requir been si should				1 🗆 Yes	2 ☐No 3 ☐ Probably 4 ☐Unknown
Records,	e law has b je 2 sl	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
la	icien: The l certificate ha rector, page	e Co	25. Was case referred to medical	OC Plane of Death	1 Yes 2 1	No 1 ☐ Yes 2 ☐ NO
of Vital	S S E	O B	examiner? 1 \(\text{Yes} \) 2 \(\text{Pro} \)	Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nersing Ho		6 ☐Other (Specify)
0 [ding Ph. h. After thi funeral	on: T	27. Manner of Death 1 ■ Matural 5 □ Pending		28d. Describe how inj	
Division	Attending r death. ector: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		28f Location (Street	and Number or Rural Route Number,
Ď	after I Direct	Certification:	4 Homicide determined	building, etc. (Specify)	City or Town, Sta	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occurr	and due to the cause	(s) and manner as stated.
	To the H within 24 To the F complete	Medical	one)	and manner stated. 29c. License number		Date signed (Month, Day, Year)
	To To		29b. Signature and title of certifier.	SMARAD R SATYALIMD DOG2172		31 / 2005
. 1				completed cause of death (Item 23a) (Type, Print)		-, 1003
H	5		SMARAD R SATYA		TY, MD	21851.
*:	Sta Registi		31. Date filed (Month, Day, Year)	005 32. Degistrar's Signature		

į	Baltimore, Maryland 21215-0036		
Ph	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	. [
ysi	Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	Fun Dire	Ex

burial-transit

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detached

/Medical Examiner physician P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1547 Robert Charles LaMar Jr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Regional Wicomica lishun If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) uneral 1 2 M 2 □ F irector 219-05-2075 86 10/27/1918 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked officer than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examination that the indiffied all 1 XYes 2 □ No Director MD Worcester Snow Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 106 N. Bay Street 21863 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Doctor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Charles LaMar <u>Anna Mae Martin</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda LaMar/Wife 106 N. Bay Street, Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 6/5/2005 **Bates Cemetery** Snow Hill, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 73a. Part1. Enter the disease, or complications that caused the dah. shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hip tracture sician 1 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Complications Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Ho 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 100 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pes 2 No 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 ☐ Natural 2 ☐ Accident 5 Pending ground level fall 1830 investigation 5 29 05 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 106 N Bay St hone Snow Hill MD 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 5/31/05 1450497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hristopher Snyder St. Salisbury MD 2/80/ 100 E. Carroll State JUN 0 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and item#18.perInf C844.6/20/05 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** May 27, 2005 8:00 Joseph Leiter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda
If Under 1 Year It Under 24 Hrs. |
Months Days Hours Min. Springhouse of Westwood Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1**X** M 2 ☐ F Yrs. Director 215-38-9927 90 May 14, 1915 New York Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 21 No Director Maryland Montgomery <u>Bethesda</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5101 Ridgefield Rd <u> 20816</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ★/es 2 □ No If Yes, Give Year or Dates: WWT I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 3 Widowed 4 □ Divorced 1 ☐ Yes 2 ☐ No Specify. Specify: ģ WWII White Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Library Elementary/Secondary (0-12) College (1-4or 5+) fited withi Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, III and BARS. <u>Associate Director</u> of Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mandelberg Eva Mendelbers Abraham Leiter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Lawrence Rd, Wellsley, MA 02181

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Loc Andrew Leiter/Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Grdns May 31, 2005 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home lo 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Arrythmia /Medical Due to (or as a consequence of) **Examiner** End Stage Renal Disease 8 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit certificate be executed Diabetes Mellitus and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached o. 9 Unknown signed by d ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Coronary Artery Disease Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Peripheral Vascular Disease certificate has l irector, page 2 s autopsy performed? 1□ Yes 3□ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 417 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2√ No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury Division 5 Pending 1X Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide ŏ the Hospital within 24 hours a To the Funeral I 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 13. D35579 May 27, 2005 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Susan J. Miller, MD

31. Date filed (Month, Day, Year) MAY 3 1

32 Registrar's Signature

6844 Tulip Hill Ter, Bethesda, MD 20816

LAUREN D. LATHAM 05-03596 RKD

			1 - For State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of Maryland / Department of Programmer State of	artment of Health and Me rtificate of Death	ental Hygie	0 0 0 ==	19839			
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month MAY	25, 2005	3. Time of Death			
	/Medic		Lauren Danielle Latham		MAY	4c. County of Death	7:32A. M			
	Examin	er	4a. Facility Name (If not institution, give street and number) CRAIN HWY SOUTH OF FAIRGROUNDS ROAD	4b. City, Town, or Location of Death BEL ALTON If Under 1 Year If Under 24 Hrs. 8	2 Data of Birth	CHARLES				
	Funeral Director		5. Social Security Number 219-29-9938 G. Sex 1 M 2 T F 7. Age (In yrs. last birthday) Yrs. Usual Residence of Decedent	Months Days Hours Min	B. Date of Birth (Month, Day, Ye ember 1	Birth Pay, Year) 9. Birthplace (State of Treign Country) 17,1986 Washington				
	yland how		10a. State 10b. County 10c. City, Town or Lo		11	0d. Inside City Limits				
	ta-f s	ctor	MD Charles La Pla		1 ☐ Yes 2X No					
	vith th	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?			
	s 23e	erai	8740 Hill Spring Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. 1	20646	ify Ves or No-	USA 14. Race - Americ	an Indian			
21215-0036	d within 72 hours after death with the Maryland Jene. r than "naturel", or Itams 23a or 28e-f show The Madical Evanilher must be notified at	by Funeral	- ↑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 X No Specify:	ican, etc.)	Black, White,				
Ö	72 ho	ted	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation	168	b. Kind of Business/Inc	dustry			
21	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	1 .		_			
121	e filed w Hygier other th		17. Father's Name (First, Middle, Last)	Student 18. Mother's Name (High Schoo	<u>'</u>			
Maryland	ed a b	o Be	Ronald Dean Latham			renreich				
ary	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rural	Route Number, C	ity or Town, State, Zip	Code)			
	1 and 2 Health Jem 27 i		Ronald Latham/Father 8740	Hill Spring Dr position (Name of Da	La Pl	lata,MD 2	0646			
ore			Cometery, crei	matory or otner place)						
Baltimore,				natius Cem. 5/28						
Ba	permit. Departr importa any inju		Flour C. En No	AREHART ECHOLS P.O. BOX 567 LA	FUNERAL	. НОМЕ,Р. .MD 2064	A.			
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Hultple I	nuivies			Onset and Death			
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	9						
	Examiner	7	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
	nted I Insit	Examine	Cause (Disease or injury							
Ó,	sician and burial-transit		that initiated events resulting in death) Last c. Due to (or as a consequence of):							
8760	death certificate be executed e attending physician and nd for use as the burial-transit	dical	d,							
9	entifica ling ph e as tl	Med	IF FEMALE:							
Вох	eath certific attending pl for use as t	ian/	A Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year			
o.		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Other (specify)						
٥,	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?			
rds	w require been sig should b				1 🗌 Yes	2 No 3 Prob	ably 4 Unknown			
Records,	e law re has be je 2 sho	ompieted			24a. Was an autopsy	prior to con	psy findings available inpletion of cause of			
E B	Th ate pag	Con			performed		2 🗆 No			
Vital	9 9	Be	25. Was case referred to medical examiner?	26. Place of Death						
of		.: To	27. Manner of Death 28a. Date of Injury 28b. Time o	f 28c. Injury at 28	d. Describe how	e 6 X ther (Specify injury occurred				
ion	Attanding or death. sctor: After by the funer	atior	1 Natural 5 Pending Month, Pay Year Injury 2 Accident investigation	Work? A_M 1 ☐ Yes 2 XNo	Driver 1	nvolved in	a water			
Division	r Attandi er death. ractor: A by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	3f. Location (Stree	and Number or Rura State) Cvain Hw	I Route Number.			
	itai or irs afte rai Diri		thghwa	4	Fairgrown		Acton, MD			
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by t	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, deatl (Check only one) 2 [XMedical Examiner: On the basis of examination and/or in and manner stated.	h/occurred at the time, date and place, ar vestigation, in my opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)			
	o the	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, I	Day, Year)			
}	- > - 0		· (ard Har Dan Ind	OCME	MA	Y 25, 2005				
0		TI I	30. Name and address of person who completed cause of death [Item 23a] (Type,							
D	63		CAROLH ALLAWMA	111 Penn Street	Baltimor	ce, Marylar	nd 21201			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2005 32. Reistrar's Signature	Sperke						

				tate of Maryland / Depa	artment of Health and M	•	9	10010
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	Reg	. No.2 U U 5	19840
	Physici /Medic	al	C	harles Paul Lookin	ngbill, Sr.	June 8	2005 Day	3. Time of Death 0118 A M
	Examin	er	4a. Facility Name (If not institution, give stree Carroll Hospital Ce		4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll Co	ounty
	uneral irector		5. Social Security Number 6. Sex 114-28-2325	2□F 7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birthr Cour 1932 Mary	place (State or Foreign http)
ryland	how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation	•		10d. Inside City Limits
е Ма	8a-f s	ecto	Maryland Carroll Co	unty Taneytown				1 X Yes 2 □ No
h with t	23a or 2 st ben	ai Dir	10e. Street and Number 64 York Street		10f. Zip Code 21787		n Citizen of What Cour Coited State	•
:1215-0036 within 72 hours after death with the Maryland	in result and welled rygelies of thems 23a or 28a-f show tem 21a nerted other than "natural", or itams 23a or 28a-f show other traumatic event. The Medical Exemination at	by Funeral Director	1 Never Married 2 Married	1 □XYes 2 □ No 1 9 5 3 -	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 XNo Specify:	ocify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours af	an "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade co.	on 16a. Deced (Give life. L	ent's Usual Occupation kind of work done during most of workil OO NOT use retired)	ng	b. Kind of Business/Ind	dustry
d 21	ther th		17. Father's Name (First, Middle, Last)	mill	L worker 18. Mother's Name		nill	
aryland should be f	rked of	To Be	George Milton Look	ingbill		ene Lego:		
Mary 12 sho	ls me		19a. Informant's Name/Relationship (Type, i		g Address (Street and Number or Rura			
C	tam 27 othar tr		Dorothy Mae Looking 20a. Method of Disposition	gbill / wife 64) 20b. Place of Disposementary, crem	York Street Tane		aryland 217 c. Location - City or To	
Pages	ant: If		1 X Burial 2 ☐ Cremation 3 ☐ Remo 1 Onation 5 ☐ Other (Specify)		the area of the	11 005 Ta	aneytown, M	Maryland
Baltimore,	Important: If Itam any Injury or otha		21. Signature of Funeral Service Licensee	ums 22	Name and Address of Facility Ski B6 East Baltimore	les Fune	ral Home Faneytown,	Md. 21787
	-		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	ons that caused the death. Do not ente ause on each line.	or the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	sician ledical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):				
	aminer		Sequentially list conditions	END STAGE	COPD		,	
, p	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionitying Cause (Disease or injury that initiated events c	Due to (or as a consequence of):	FAILURE DU	E TO	NEURO	
760, <	sician and burial-transit	Ä	that initiated events resulting in death) Last	RESPIRATORY Due to (or as a consequence of): D MUSCUL AR	HTIW 32A 321		TRACHEOST	· MY
6876 ifficate b	چ. B	edicai	d					
Vital Records, P.O. Box 68 sician: The law requires that the death certifica	y the attending pl ched for use as t	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	nry Day Year
S, D	signed by the a be detached f	by P	Part II. Other significant conditions contribu		derlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ord:	been sig	ted	DIABETES	MELLITUS		1 Tes	2□No 3□Prob	ably 4 Dunknown
	ate has page 2	Completed	ARRYTHM,A			24a. Was an autopsy performed	prior to cor	psy findings available inpletion of cause of 2 No
Vita	certificate rector, pag	o Be	25. Was case referred to medical examiner?	ital:	26. Place of Death			
Division of Vital or Attanding Physician:	tor: After this certific the funeral director,	\vdash	27. Manner of Death 2	1 ☐ Inpatient 2 ☐ ER/Outpatient 8a. Date of Injury (Month, Day Year) 28b. Time of Injury		ne 5 ∐ Hesidenc 28d. Describe how		"
Sior	or: Aft	catio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No			
		Certification:	3 Suicide 5 Could not be 4 Homicide determined 2	 Place of Injury - At home, farm, stre building, etc. (Specify) 	eet, factory, office	28f. Location (<i>Stree</i> City or Town, S	at and Number or Rura State)	l Route Number,
Di To the Hospital or	To the Funeral Directompletely filled in by	edicai	(Check only 2 Medical Examiner:	in: To the best of my knowledge, death On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the caus and at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
Tot	Tot	Σ	29b. Signature and title of artifier	La M.D	29c. License number D0054586	1	Date signed (Month, $06/08/$	Osy, Year)
(11			4.D. 417 E B			PANEYTON	N MD2178
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3 200	32. Figistrar's Signature	act i			
DHMH 1	17 Rev 1/2		A 411 O #1881	Branco 12 19				

		-	State Registrar	$C\epsilon$	ertificate of Death	Reg.	No.	10041
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	CLARA G. MAYNARD 4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Death		2005 4c. County of Death	7:53 P ^M
	Examin		SOMERFORD PLACE ASSIS	STED LIVING	ANNAPOLIS		QUEEN ANN	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birthday 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, You OCT. 14,	9. Birthpl Count 1911 MAIN	lace (State or Foreign try) IE
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10	Od. Inside City Limits
	e Man	Director	MD ANNE ARUNDEI	ANNAPOLIS				1 ☐ Yes 2 XNo
	with th	Dire	10e. Street and Number		10f. Zip Code		. Citizen of What Coun	itry?
	ms 23	Funeral	2717 RIVA ROAD 11. Marital Status 12. Wa	s Decedent Ever in U.S. 13	21401 Was Decedent of Hispanic Origin? (S)	pecify Yes or No-	14. Race - America	
920	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23e or 28e-1 ehow any injury or other treumatic event, the Modical Examination and other treumatic event, the Modical Examination and other treumatic event.	by	1 Never Married 2 Married 1 If Y	ned Forces?]Yes 2 No es, Give ar or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:	o Hican, etc.)	Specify: WH	etc. [ITE
2	72 ho netur	eted	15. Decedent's Education (Specify only highest grade comp	oleted) (Giv	edent's Usual Occupation e kind of work done during most of work	king 16	b. Kind of Business/Ind	dustry
21215-0036	within iene. than	Completed	Elementary/Secondary (0-12) Col	llege (1-4or 5+)	DO NOT use retired) MAKER		OWN HOME	
b	al Hyg I other vent,	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma.		
Maryland	ould b	Tof	GEORGE C. GRAY	1		M. HOWE		Onda)
Mar	d 2 sh th and th and 7 is m treum	1 5	19a. Informant's Name/Relationship (Type, Pri	6	ling Address (Street and Number or Ru OYSTER COVE DR.,			638
	s 1 an if Heal item 2 other		20a. Method of Disposition	20b. Place of Disp	position (Name of		c. Location - City or To	
<u><u>E</u></u>	Page ment o ent: If ury or		1 ☐ Burial 2 M Cremation 3 ☐ Remova `4 ☐ Donation 5 ☐ Other (Specify)	CHESAPEA CENTER,	PE POEMATION	5/2005 S	TEVENSVILLE	E, MD
Baltimore,	Depart Depart Import any inj	5	21. Signature Frage Stryice Licensee	/// F	22. Name and Address of Facility ELLOWS,HELFENBETT 06 SHAMROCK ROAD,	N & NEWNAM CHESTER,	FUNERAL H MD 21619	OME, P.A.
	Pnysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition					Approximate Interval Between Onset and Death
	/Medical		resulting in death)					7
	Evaminer			Due to (or as a coulquence of):	21.			/
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Que to (or as a conjuence of):	ive heart t Henosis			years
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50,		I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Yenosis			years
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P.O. Box	e law requires that the death certilicate be executed has been signed by the attending physician and pe 2 should be detached for use as the burial-transit	Physiclan/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributions	Due to (or as a consequence of): Pes, outcome of pregnancy Live birth 2 Petal death 3 Pregnant at time of death 5 Unknown	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did tobac 1 □ Yes 24a. Was an autopsy	23d. Date of delive Month 22 No 3 Probi	Day Year ne cause of death? nably 4 □Unknown psy findings available mpletion of cause of
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,				1 - State Registrar Certificate of Dea	ath		leg. No.	U5_	198	46
		Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day	Year	3. Time of	
		/Medic	al	William John Maslar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca	tion of Dooth	June		2005 y of Death	0210	A M
		Examin	er	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice Baltimore			40. 00011	y or Death		
	()	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birth) Vearl	9. Birthi	place (State or	r Foreign
		Director		199–20–9468 TWM 20 7 76 Yrs.	ours Min.	8. Date of Birth (Month, Day SEPT 2,	1928		nsylvar	nia
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					IOd. Inside Cit	ty Limits
	,	Maryi:	tor	Delaware New Castle Bear					1 🗀 Yes	2 X No
		r 28a	irec	10e. Street and Number 10f. Zip Code			10g. Citizen of	What Cou	ntry?	
		th with	Funeral Director	127 Marble House Drive 19701			Unite	ed Sta	ates	
		tems	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Spe exican, Puerto f	cify Yes or No- Rican, etc.)	14. Ra Bla	ce - Ameri ack, White,		
	36	rs afte	by Fi	1 17Never Married 2 Married 1	ecify:		Speci	fy: Wh	nite	
	0	2 hou	ted t	15 Decedent's Education 16a Decedent's Usual Occupation			16b. Kind of E			
	215	thin 7: 9. Ban "n Medi	Completed	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0·12) College (1·4or 5+)	most of workir	ng				
	21	ygien ygien erth	Con	5+ Parish Priest	Adams de Nieuw	(Fi - A - A A i - J - II -	Relig			
	and	il be fi	Be		Mother's Name					
	Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. It is marked other than "natural", or items 23s or 28s-f show aumstic event, the Medical Examinar mast be notified at	10	John Andrew Maslar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	Mary Ba: Jumber or Rura				Code)	
	Ž	alth a		John W. Maslar/Brother 127 Marble House	e Drive	, Bear,	Delawa	are 19	9701	
	ore,	es 1 a of He of He fitem		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemelery, crematory or other place)	June	13.	20c. Location Mahan	- City or T	own, State	
	Ë	Pag ment tant: I		'4 Donation 5 Other (Specify) St. Mary's Cemetery	200.	5	Pennsy	lvan	ia	
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Informant: if them 27 is marked other than "natural", or Itams 28 or 28a-1 show any injury or other traumatic event, the Madical Examination must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Hicks Home for 103 W. Stockt	Facility or Fune: ton Str	rals, P	.A.	Marv1	and 210	221
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.				iai y i	Approximate Interval Bety	een
•		nysician	07	Immediate Cause (Final disease or condition a Pancretic Cancer					Onset and D)eath
-		/Medical Examiner		resulting in death) ue to (or as a consequence of):						
		LAGIIIIII	100	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				-		100
m,		uted 1 ansit	Examiner	cause. Enter Underlying Cause julisease or injury						
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8	ord	equire sen si				1 🗆 Y	es 2 No	3 🗌 Pro	oably 4 □U	nknown
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Z	1 0	g Phy er this ieral c	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		28d. Describe h				100
7	sior	endin sath. or: Aft he fur	atlo	2 Accident investigation M 1 Yes	2 🗆 No					
WILLAM	Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (S City or Tow	Street and Nurr m, State)	nber or Run	al Route Num	ber,
7	_	Hospital or 14 hours afte Funeral Dire tely filled in t	CC	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, da	ate and place, a	and due to the	cause(s) and n	nanner as s	stated.	
.≥		the Ho nin 24 I the Fu	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinior one))
		Neith Con	Σ	29b. Signature and title of certifier 29c. License nun			29d. Date sign			
		0.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETSO MD Richey Hospice 838 N. Ewlaw	1 /0	•	JUNE	1,0	JU J	
		13		ETSO MD Richey Hospice 838 N. Eutaw	St. 7	Baltim	LOVE M	D 21	201	
		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
)		Registi	rar	JUN 1 4 2005 Bleeve & Soule						

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** May 26,2005 11:53a MAZONGE **AMULAWM** MUSSA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Springs Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🖫 F Yrs Oct. 24, 1958 Tanzania 46 Director Unavailable Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c, City, Town or Location 10a State 10b County ir then "naturel", or items 23a or 28e-f show the Medical Examinar must be nutified at Yes 2□No Greenbelt Funeral Director Maryland Prince Geo. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20770 9180 Springhill La. Tanzania filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 Pages 1 and 2 should be filed very thent of Health and Mental Hygiestent: If Item 27 is marked other to jury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Davdi Achotto Mussa A. Mazonge 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 50 Secor Rd, Scarsdale, New York Maskini Steiner- Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State permit. Page
Department o
Importent: If
any injury or
once. Geo. Wash. Cemet. 5/27/05 Adelphi, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal II Mortuary Inc. Funeral Service Licensee 20011 411 Kennedy St, N.W., Wash, D.C. 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cryptococcal Meningitis 2days Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No ò 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2€ No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 ☐ Yes 2€ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Medical and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60826 5/26/05 sha 2 30. Name and address of person who completed buse of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Springs, Maryland 20910 Kshama Garq, M.D. 39. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 31 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mayonth 28, Day 2005 Year **Physician** Alphonse Joseph Madello 10:10 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2200 Windham Lane Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 12, 1923 Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral №** M 2□ F 088-14-3483 82 Yrs Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes Ž ☐ No Silver Spring Directo Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 5 2200 Windham Lane 20902 Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify. White Baltimore, Maryland 21215-0036 ö 1 ☐ Yes Ž ☐ No Specify: If Yes, Give Year or Dates: 1942-46 3 Widowed 4 Divorced Completed by "naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Army Corps. of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Engineers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If them 27 is marked oth any Injent; or puther treumetic event once. Be Vincent James Madello Ann Lucian 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 Windham Lane, Silver Spring, MD 20902 Joyce K. Madello/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Fiancisal Adorilins Tuneral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Leukemia Weeks Priysician /Medical Due to (or as a consequence of): Examiner Months Myelodysplastic Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter the charge Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ed by Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an page 2 s autopsy 2 □ No Yes of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 ☐ Yes 2X No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Division 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital within 24 hours a To the Funerel Completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier d42452 May 29, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Olney, MD 20832 Chitra Rajagopal, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			- Tea	State of M	aryland / D					-	_	w grow	10015
			For State Registrar		-	Certificat				, ,	g. No.	Jo	19845
			1. Decedent's Name (First, Middle						2	. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		ROSE	NWAKWA	A	MBOGU			N	IAY 3	0, 20	05	9:40 a M
	Examin		4a. Facility Name (If not institution			,		Location of	of Death		4c. County		IOD GEG
			WASHINGTON ADV 5. Social Security Number		LTAL ne (In yrs. last birti		KOMA	PARK If Under 2	24 Hrs. lo	Date of Birth	PRIN		EORGES
	Funeral Director		212-65-2822	1□M 2√F	-	rs. Months		Hours	Min.	(Month, Day, JAN 1,	1922	MBUT	place (State or Foreign ntry) LU-UKWU
	ס		Usual Residence of Decedent										
	arylar show	_	10a. State 10b. County		10c. City, Town							1	10d. Inside City Limits 1, Yes 2 □ No
	the M	ectc	MD. PRINC	CE GEORGES	RIVER	DALE 10f. Zig	Code			10	g. Citizen of V	Vhat Cour	11
	with Ba or	Funeral Director	5600 54th AVENU	JE APT. #50	01		20737	,		ì	NIGERI		itty:
	death ms 23	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece			gin? (Specif		14. Rac	e - Americ	can Indian,
9	or Ite	II.	1 Never Married 2 Marr	Armed Forces? ned 1 ☐ Yes 2 🏋 If Yes, Give		1 Yes		Specify:	i, rueno Aio	an, etc.)		k, White, : BLA	
8	be filed within 72 hours after death with the Maryland lal Hygiene. id other then "neturel", or Items 23a or 28a-f show event, I'al Picifical Exur: if wit must be Lediffed at	d by	3 Widowed 4 Divorced	Year or Dates:		<u> </u>							
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b	al Hyg I otha vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name (F	First, Middle, M	laiden Surnan	10)	
ylaı	Menta Menta arkad	To E	SUNDAY NWAKWA							HEONUNE			
Maryland 21215-0036	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, If a Pecical Exercited interface celling an ange.		19a. Informant's Name/Relations PLEASURE NKWOO	_		Mailing Address				RIVERD.			20737
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Baltimore,	ages ant of it: If it		1 Surial 2 Cremation 4 Donation 5 Other (S	3 ☐Removal from State	1	y, crematory or o Y CEMET		1	06-14-	-05	LAGOS,	NIGE	ERIA
慧	ourtme corten rinjur	l	21. Signature of Funeral Service		FAULL	22. Name a	nd Addres	s of Facility	y W. H	I. BACO	N FUNE	RAL H	HOME, INC.
ä	Depurition Deputition		Wanda	C. Bacon	c. CC36	3447	14th	STREE	ET, N	WAS	HINGTO	N, DC	20010
ı			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cause only one cause on each I	d the death. Do n	ot enter the mo	de of dying	g, such as	cardiac or r	espiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SE	PSIS								Onset and Death 2 Culcu
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	1.1	0	150	MOX	110		es , M
		20	Sequentially list conditions,	b. Due to for as	a consequence of		14.	/	16 4	11101	1/17	-7	a Visca
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x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome	of programmy								
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p					23d. Da Mo	te of delive nth	ery Day Year
Ö	the de y the sched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	timo or doubt	0 (3)	JOO!! Y/						
Δ.	s that ned b e deta	y Pt	Part II. Other significant condition	ons contributing to death I	out not resulting in	the underlying	ause give	n in Part I.		23e. Did tob	acco use cont	ribute to th	he cause of death?
Vital Records,	equire en sig ould b	ed b	Endsta	ige Ke	hal	clise	ast	2		1 □ Ye	s 2 X No	3 🗌 Prob	bably 4 Unknown
eco	law re as be 2 sho	plet	Rectal	1000 (a)	08e.					24a. Was ar autopsy	/	prior to co.	opsy findings available impletion of cause of
0	The rate h page	Corr		/						1 Yes 2		death?	2 No
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:			Otho			Check only one			
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on	Attending r death. sctor: After by the funer	tlon	1 Natural 5 Pendir 2 Accident investi		ıy Year) tr	njury M	28c. Injury Work 1 🗀 Y	(? /es 2.□!			,,		
Division	Atter	Certification:	3 Suicide 6 Could 4 Homicide determ	ninger 289, Place of In	jury - At home, fai tc. (Specify)	rm, street, factor	y, office		281	f. Location (Str City or Town		er or Rura	al Route Number,
Ö	rs after set of the set in ed in	Cert	Λ	Building, 6	to. (opcomy)								
	Hospital or 24 hours afte Funerel Dir tely filled in	edical	(Check only 2 Medical	ng Physician: To the best Exeminer: On the basis	of examination and								
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Med	one) 29b. Signature and title of certifie	and manner s	aled.	29	c. License	number		29	d. Date signe	d (Month,	Day. Year)
)	- 3 ± 8		X MILL OU	un K	Cal-	7	019	160	9		5.30	-0	5
)	(3)		30. Name and address of person	who completed cause of	death (Item 23a) (Type, Print)	350	3 9	PERI	84	TDE	ET	
			MOUNTR	AINIER.	MD	207	12) [01-0	-	, , , e c	- /	
	Sta		31. Date filed (Month, Day, Year,		rar's Signature	6.0.							
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			For State Registrar		State o	of Mary			rtmen				lental Hy	giene Reg. No.	JUJ	198	346
	Dhysisi		1. Decedent's Name (First,	Middle, Las	st)								2. Date of Dea	ath Day	Year		ne of Death
	Physicia /Medic		James Edwa	ard	Mc	Cassie	Jr.						May 29,			7:3	O A M
	Examin	er	4a. Facility Name (If not ins								Location	of Death			County of De		
			Hospice of t				use to at hint	- da \	Lint If Under	hic	um If Under	24 Hre	O Data of Bird		ine Aruno		
	Funeral Director		5. Social Security Number 010-34-4442	6. S	ex XXXI2□F	7. Age (III 61	yrs. last birth Y	rs.	Months	Days	Hours	Min.	8. Date of Birt May 24,	n 1944)	Ma.s	innpiace (St Country) SSACTIUSE	ate or Foreign
			Usual Residence of Decede	ent													
	yland		10a. State 10b. C	ounty		100	. City, Town	or Lo	cation							10d. Insid	de City Limits
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	h with the	al Director	10e. Street and Number 12701 Piscataw	ay Roa	d				10f. Zip	Code 207	'35			10g. Citi	zen of What 0 USA	Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination of the routilied at once.	by Funeral	11. Marital Status 1√√ Never Married 2 3 □ Widowed 4 □ Div		12. Was Dec Armed Fo 1 XXYes If Yes, Gi Year or D	orces? 2 No ve	in U.S.	11	Vas Deced i Yes, spec	ify Cuba	ispanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - An Black, Wh Specify: W	nite, etc.	ın,
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and	d be f antal f ed of	9 Be	James Edwar										. McDonald		00,110,		
Z	should Me mark	ဥ	19a. Informant's Name/Rei				19b.	Mailin	g Address	(Street a			al Route Numbe		r Town, State	Zip Code)	
≅	nd 2 s lth ar 27 is r trau		Richard Latham	. , ,						•			on, Mary	-	20735	, , ,	
ē,	t Hea t Hea ttem other		20a. Method of Disposition			i	Ob. Place of	Dispo		ne of	I		Date		cation - City	or Town, Stat	te
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alti	mit. J partm sortai / inju	11	21. Signature pneral Se				id Id D	22	Name an	d Addres	s of Facili	hv			- 5		
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B	/Medical Examiner		resulting in death)		Due to	(or as a co	nsequence o	f):									
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O. Box (that the death certifica ed by the attending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 🗍 nant at time	Fetal death		Ectopic pro Other (sp					2	23d. Date of d Month	elivery Day	Year
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			27. Manner of Death 1 X Natural 5 □ I	Pending	28a. Date (Mor	of Injury oth, Day Yea	ar) 28b. Ti	me of jury		8c. Injury Work	</td <td></td> <td>28d. Describe h</td> <td>now injur</td> <td>y occurred</td> <td></td> <td></td>		28d. Describe h	now injur	y occurred		
sio	Attending r death. ector; Afte by the fune	cati	2 Accident	nvestigation Could not b					М		Yes 2□	No	206 1	34	d 81	D	A1
Division	or A or A Direction by	Certification;		determined	286. Flace	e of Injury - ing, etc. (S	At home, fan oecify)	m, stre	et, factory	, office			28f. Location (S City or Tox	vn, State	a Number or i)	Hurai Houte i	Number,
	8 5 8		29a. Certifier 17 Ce	rtifying Ph	ysician: To the	e best of my	/ knowledge,	death	occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s)	and manner	as stated.	
	e Hospit	edical	(Check only 2 Me	dical Exar	niner: On the b	pasis of exa	mination and	Vor inv	estigation,	in my op	oinion, dea	ith occur	red at the time.	date and	place, and di	ue to the cau	ISO(S)
	To the within 2 To the complet	Me	29b. Signature and title of	certifier		~~~	. 1.		290	. License	number			29d. Dat	e signed (Moi	nth, Day, Yea	ar)
}			Ma	du (J. Cu	eet	z u	<u>^</u> .		D23	3743		N	May 3.	1, 2005		
R	- (5)		30. Name and address of p Martin Welt	erson who	completed cau 7525 Gre	se of death enway	(Item 23a) (T Court D	rype, rive	Print) e Coli	umbia	, Mary	land	20779				
	Sta Registr	- 5	31. Date filed (Month, Day, JUN 0			Registrar's S	Signature	204	K)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 348 **Physician** May 27, 2005 Robert Henry Mills /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner pheamico 501156410 Keelonal eninsula Medica/ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number **Funeral** Days Hours 1∏M 2□ F Yrs Director 218-16-5428 12-28-14 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f ahov traumatic event, the Medical Examinar must be notified at 1 TYes 2 □ No Director MD Worcester Pocomoke City 10g. Citizen of What Country? 10e. Street and Number ö Itema 23a Newtown Apt b-5 21851 USA 1012 Market St Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2√DXNo Specify: SpecifBlack þ 3 Widowed 4 Divorced *natural. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is markad other than °r Trucking Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ Flossie (maiden unknown) John Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) İ it of Health 508 Cedar St Poconoke City, MD 21851
ce of Disposition (Name of Date 20c. Location - City or Town, State Karen Downing/daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9 permit. Page Depertment of Important: If any Injury or once. Girdletree, MD Cool Springs UMCC 6/2/05 21. Signature of Funeral Service Licenses Bennie Smith Funeral Home 819 4th Street

23a. Parti Unfer the discussed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22. Name and Address of Facility Immediate Cause (Final disease or condition resulting in death) Jaunelice. leuntitis Physician /Medical Due to (or as a consequence of) Examiner Commin the du if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-translt death certificate be executed Due to (or as a consequence of) the IF FEMALE Box (23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown divise Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 2 No 1 Yes certificate Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Dinpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 - Homicide 24 hours a Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Noto

30. Name and address of person w

31. Date liled (Month, Day, Year)

MAY 3 1 2005

no completed cause ol death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr Kota Chandrasekhara 306 Kay Avenus

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State of Maryland / Department of Health and M	lental Hygiene()	0.5

			For State Registrar		State	от ма	ryland		irtment of <i>tificate o</i>				glene Reg. No.	UÜ) [904	10
	Physicis	200	1. Decedent's Name (First, Mid	dle, Last)								2. Date of De Month	Day		'ear	3. Time of	
	Physicia /Medic	al -	NANCY HENDRICE						4b. City, Town	ortona	tion of Dogth	MAY	22 4c Cc	2 ounty of	005	6:54	P [™]
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-	Funeral		5. Social Security Number	6. Sex		7. Age	(In yrs. las	st birthday)	If Under 1 Ye		nder 24 Hrs.	8. Date of Bir (Month, Da				ace (State or	Foreign
	Director		216-38-8037	1]M 2 ∏ F		66	Yrs.	Months Day	75 110	IVIII.	MAY 16	, 1939		OHIO		
	and **	-	Usual Residence of Decedent 10a. State 10b. Cour	ity			10c. City,	Town or Lo	cation						10	d. Inside Cit	y Limits
	Marylan f show	Į	MD ANNI	E ARU	NDET.		ANN	APOLI	S							1 🗌 Yes	2 X No
	r 28e	Director	10e. Street and Number	ARO	NDLL		211111	ZII OLL	10f. Zip Code	9			10g. Citizer	n of Wh	at Count	ry?	
	th with		1037 J SPA ROA	AD					2140				USA				
	items items	Funerai	11. Marital Status		12. Was Dec Armed F	orces?		. 13. V	Vas Decedent of Yes, specify C	f Hispan uban, Me	ic Origin? (Spe exican, Puerto	ecity Yes or No Rican, etc.)	j- 14.		America White, e	an Indian, etc.	
3	72 hours after death with the Maryland natural', or Hems 23e or 28e-f show Steal Exeminent intellier incitified at	by Fi	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 🏋 Divorc		1 ∐Yes If Yes, G Year or I	ive	0	-	☐ Yes 2 X N	lo Sp	ecity:		S	ecify:	WE	HITE	
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, de	should and Men marke umatic	ရ	DUDLEY HENDRI 19a, Informant's Name/Relation		roe Print)			19b. Mailin	g Address (Stre			FEREE	er. City or T	own, Si	tate, Zip	Code)	
2	and 2 s ealth an n 27 is i		DAVID ALLEN N						CHICKA					012			
נ	of Health of Health fitem 27 r other tr		20a. Method of Disposition				20b. Pla	ce of Dispo	sition (Name of			Date	20c. Loca	tion - C	ity or Tov	wn, State	
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	permit. Page Department of Important: If any injury or otice.		21. Signature of Funeral Servi	ce Licens	R	90.	ott	_ A A	Name and Ad DAMS FU NNAPOLI	ness of INERA	Facility L & CRI D 2140	EMATION	CARE	, 81	4 BE	STGAT	E RD.
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	/Medical Examiner		resulting in death)		Due to	o (or as a	conseque	ence of):									
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2	leath certif attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	2		birth 2	or pregnan 2 Fetal of time of dea	death 3	Ectopic pregna Other (specify				230	d. Date Monti	of delive:	•	'ear
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5	Phys	.: To	1 ☐ Yes 2 ☐ No 27. Manner of Death		28a. Date	e of Injur	у :	R/Outpatier 28b. Time of	28c. li	njury at		ome 5 Res				RESI	DENCE
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2	r Atter	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ald not be ermined	28e. Plac	ce of Inju	ry - At hon :. (Specify)	ne, farm, str	eet, factory, offi	ce		28f. Location (City or To	Street and I wn, State)	Vumber	or Rural	Route Numi	ber,
5	itel or rel Di rel Di																
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medic one)	cal Exami	ner: On the		examination		n occurred at the vestigation, in m	ny opinior	n, death occur		date and p	ace, an	d due to	the cause(s)	
	with To t	Σ	29b. Signature and title of cert	itier	0		1		29c. Lic	ense nun	nber	/	29d. Date :	signed ((Month, E	Day, Year)	-
			30. Name and address of pers	on who c	ompleted ca	use of de	eath (Item	23a) (Type,	Print)	101	2110		1112	7	0)	2003	f , = 5
	014		30. Name and address of pers	UAT	KIM	Prinistra	2 ar's Signati	900	BES)	T 6 10	7万色 /	10 /	ANNA	you	SY	m 21	40)
	Sta Registr		MAY	3 6 2	005	Rece	ARI D	& A	posti								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** William Naimark 2005 May 8:30 /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda 10649 Montrose Avenue Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1[XM 2□ F 89 Yrs Director 27, 1915 New York 076-10-3618 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23e or 28e-f ehow other treumetic event, the Madical Examinar must be notified at 1 ☑ Yes 2 ☐ No MD Director Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10649 Montrose Avenue 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No White Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Judge Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be to Department of Health and Mental I Importent: If Item 27 Is marked of Edna Unger Aaron Naimark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11315 Commonwealth Dr #102 Rockville MD 20852 Laura Naimark, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Parklawn Mem. Gardens May 29, 2005 Rockville, MD injury * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home Inc. 21. Signature of Funeral Service Licensee any in 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the disk se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallow. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Fntar Undarlying Cause (Disease or injury b Due to (or as a consequence of): Examiner burial-transi that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) the 1 Yes 2 No page 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2X No 1 ☐ Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 1 Thpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation death. filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check on

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physicien: within 24 hours after death To the Funerel Director: To the Hospital

Baltimore, Maryland 21215-0036

12

Registrar

29b. Signat

Collin D. Cullen,

31. Date filed (Month, Day,)

Règistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

M.D. 5454 Wisconsin Avenue, #1625 Chevy Chase, MD 20815

MD0052247

29d. Date signed (Month, Day, Year)

May 27, 2005

	1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and M rtificate of Death	lental Hygien	2005 10050
Dhusisian	Decedent's Name (First, Middle, Last)		-	2. Date of Death	Day Yeer 3. Time of Death
Physician /Medical	Leroy Nelson			May 2	6 2005 10:28 A ^M
Examiner	4a. Facility Name (If not institution, give s Prince George's H		4b. City, Town, or Location of Death	4	Ic. County of Death
Eupovot	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	Cheverly If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince George's
Funeral Director		M 2□F 87 Yrs.	Months Days Hours Min.	(Month, Day, Yea Aug. 19,	r) 9. Birthplace (State or Foreign Country) Virginia
pu 🛦 .	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits
Maryle f sho	,				1 X Yes 2 ☐ No
with the Mai or 28a-f s be notified	Maryland Prince G	eorge's	Capitol Heights 10f. Zip Code		Citizen of What Country?
h with	1159 Booker	Drive	20743		United States
ofter death virtues 23.	11. Marital Status	Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
urs afte	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	, 23-3,	Specify: Black
tural stural	15. Decedent's Educ	Year or Dates:	dent's Usual Occupation	16b.	Kind of Business/Industry
ed within 72 ho or than "natura or than "natura t, the Mulcall	(Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	e kind of work done during most of work DO NOT use retired)	ng	,
A with a	6th	00.10g5 (1.40.01)	Cab Driver		Self-Employed
be fill Hy adoth Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	
hould d Men marke matic	Isaac Nels		ng Address (Street and Number or Rura	Hester I	
Man Han and 2 s 1s 1s 1s 1s 1s 1s 1s 1s 1s 1s 1s 1s 1	Jean C. Worth -			20	
item other	20a. Method of Disposition	20b. Place of Disp	1305 Congress St position (Name of matory or other place)	Date 20c.	Location - City or Town, State
mit. Pages partment of portant: if it y injury or o	1 Burial 2 Cremation 3 Re `4 Donation 5 Other (Specify)		oln Cemetery 6/3/	2005	Brentwood, MD
permit Pages 1 and 2 should be titled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is an exted other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Montal Examination of the continuous of the Completed by Funeral Director. To Be Completed by Funeral Director.	21. Signature of Funeral Service License	Tronk III	 Name and Address of Facility S 4001 Benning Rd. 		neral Home Sh., DC 20019
MENT!	23a. Part1 Enter the disease, or complic shoot, in heart failure. List only on	ations that caused the eath. Do not en	ter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between
Physician	Immediate Jause (Final disease or condition		AC ARRHYTHMIA		Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
executed executed and and ital-transit	Cause (Disease or injury				
exective and and rial-tra	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
portou, icate be executed physicien and s the burial-transit	d.				
entific fing plans to as t	IF FEMALE:				
nat the death certification by the attending pleached for use as the Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
that the de ed by the detached	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown			
w requires that should be dett	Part II. Other significant conditions conf	ributing to death but not resulting in the c	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
aquire en signal				1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 XUnknown
The law requires the has been spage 2 should				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
: The				performed?	
vital necessions. The law secretificate has built director, page 2 so Be Comple	25. Was case referred to medical examiner?	ospital:	26. Place of Death		
Attending Physician: The adeath. ector: Atter this certificate he by the funeral director, page tiffcation; To Be Com	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of Injury 28b. Time of	THE SELECT 4 NUISING HOL	ne 5 ☐ Residence 28d. Describe how inj	6 ☐Other (Specify) ury occurred
nding ath. r: Afte e fune	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
tal or Attending F is after death. al Director: After ed in by the funer Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
urs afformal or all of irrelation or all of irrelat					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral bifer death. To the Funeral bifer to: Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification; To Be Completed by Physician/Medical Examir	29a. Certifier (Check only one) 1 Certifying Physical Examin	cian: To the best of my knowledge, deat er: On the basis of examination and/or in and manner states.	th occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the cause(ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
within To the comp	29b. Signature and title of certifier	//~	29c. License number		Pate signed (Month, Day, Year)
. 1	Mondell	Seesa mo	D53209		5/27/05
406	30. Name and address of person who cor DR WENDELL PIERS	SON 3001.	HOSPITM DRIVE	CHEVE	5/27/05 ERLY, MD 20185
State Registrar	31. Date filed (Month, Day, Year). JUN 0 1 2005	32. Registrar's Signatur			1

			For Stata Registrar	State of Mar	yland		artment o				giene Reg. No.	000	19851
۰	- · · ·		1. Decedent's Name (First, Middle, Last)						2. Date of De	ath Day	/ Year	3. Time of Death
	Physici /Medio Examin	al	Evelyn Elaine 4a. Facility Name (If not institution, give	Peay street and number)			4b. City, Tow	n, or Locat	ion of Death	May 3	1, 3	2.0.0.5 County of Death	2:45P M
			Frederick Memo	rial Hosp	pita	a 1	Fred	derio	k		I	rederi	ck
	Funeral Director		5. Social Security Number 6. Se 577-54-6212	x 7. Age ☐M 2⊠XF	(In yrs. Ia 63	st birthday) Yrs.	If Under 1 Y	ear If Ur ays Hou	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da Feb. 21	y, Year)	9. Birth Coo 942 Wash	nplace (State or Foreign untry) ington, D.C.
	p >		Usual Residence of Decedent 10a. State 10b. County	1.	ine City	, Town or Lo	nation						10d. Inside City Limits
	shov	5			100. Oity,								1 ves 2 □ No
	the N	Director	Maryland Frederic	K		Frede	10f. Zip Cod	de		1	10g. Citi	izen of What Co	untry?
	with 3a or		700 A 17 11 Design				2170				_	ted Stai	
	ms 2	Funeral	789-A Wembley Driv	12. Was Decedent Ev	er in U.S	3. 13.			o Origin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Amer	ncan Indian,
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 250 No If Yes, Give			ives, specπy 1 □ Yes 2 ☑		xican, Puerio ecify:	rican, etc.)		Specify: B1	_
21215-0036	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show disal Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:									
<u>7</u>	"net	Completed	15. Decedent's Ed (Specify only highest grad			(Give	dent's Usual Oo kind of work do DO NOT use re	one during	most of work	king	16b. Ki	ind of Business/I	ndustry
12	filed within Hygiene. ther then "ther out, the Med	m d	Elementary/Secondary (0-12)	College (1-4or 5+))		stered					Health	Care
9	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "neturel", or Items 23a or 28e-1 show event, I're Medical Examinar must be notified at		17. Father's Name (First, Middle, Last)		-	пові	Beereu			e (First, Middle	, Maiden		
lan		To Be	Edward Downs					(Charlo	tte Tur	ner		
Maryland	s 1 and 2 should if Health and Men item 27 is marke other treumatic.	-	19a. Informant's Name/Relationship (7	уре, Print)		19b. Mailir	ng Address (St	reet and N	umber or Rui	ral Route Numb	er, City o	r Town, State, Z	ip Code)
Σ	1 and 2 Health tem 27 i		Reginald A. Peay /	Son	. 10					own, MD			
ore	000-		20a. Method of Disposition 1 Burial 2 SCremation 3	Removal from State	1		sition (Name o natory or other			e 1,	20c. Lo	ocation - City or	Town, State
Ë	Pag tment tent: jury o		* 4 ☐ Donation 5 ☐ Other (Specify		Rest		Cremat		20	05	Fre	derick,	Maryland
Baltimore,	permit. Pag Department Importent: b eny injury o		21. Signature of Fun 11 Secure 11 mm	7		R	2. Name and A esthave 501 Cat	en Fur	neral	Service Hwy. F	s, S	kkot Coo rick, M	dy P.A. 21701
			23a. Part1. Enter the disease, or composite shock, or heart failure. List only	lications that caused the cause on each line	he death.	. Do not ent	er the mode of	dying, suc	h as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	INT	ma	cran	VIAL	HEM	mari	1102			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):	VIAL ENTEN		21				
	LAdimine	_	Sequentially list conditions,	b. Due to for as a			そしっとへ	15701	✓				
	ted	Examiner	tany leading to intri-ediate cause. Enter Underlying Cause (Disease or injury	The to got as a	CONTRACT ACT	Offisio Origi							
	execu n and al-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as a	consequ	ence of):		·					
8760,	icate be executed physician and s the burial-transit	Ical		d									
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit										- 1	Į.	
XO	eath certific attending p	Physician/Med	230. was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			∃Ectopic pregn	ancy			(4)	23d. Date of deli Month	very Day Year
O. B	e dea the at	Sici	in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	4□Pregnant at ti 9□Unknown	me of de	ath 5[Other (specif	y)		-		WOTET	Day Teal
P.0	res that the de signed by the a be detached t		Part II. Other significant conditions co	entributing to death but	not resu	lting in the u	nderlying caus	e aiven in F	Part I	23e. Did 1	obacco u	use contribute to	the cause of death?
ds,	signe d be o	d by	Turing of the state of the stat	on the same of the			. i.doriy iiig daad	3		1 🗆	Yes 2	⊠No 3 Pro	bably 4 Unknown
ecords,	w requir been si should	ete								24a. Was	an	24h Were au	topsy findings available
Rec	The lav ate has page 2	Completed								auto perfo	psy ormed?	prior to death?	ompletion of cause of
Vital	ician: Th certificate rector, pag	C	25. Was case referred to medical					26.5	Place of Dea	1 ☐ Yes th (Check only	255 No	1 Yes	2 No
>	Physician: this certificatal director,	0	eyaminer?	Hospital:	t 2 🗆 E	ER/Outpatie	nt 3 DOA					6 □Other (Spec	cify)
1 of		T:u	27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time o		Injury at Work?		28d. Describe			
Ö	Attending r death. sctor: After by the fune	atlo	1 Natural 5 Pending investigation		,	,,	M	1 Tyes	2 🗆 No				
Division	l or Atter after de Directe	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At hor (Specify	me, farm, st	reet, factory, of	fice		28f. Location (City or To	Street an wn, State	id Number or Ru i)	ral Route Number,
	urs al		COn Contilion 155 Contituing Ch	uninima. To the best of		ula dea daat	h		to and since	and due to the	221150/2	l cod messos co	atatad
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	Medical		ysician: To the best of liner: On the basis of e and manner state	examinati								
	To the within Fo the complex c	Me	29b. Signature and title of certifier	1				cense num			29d. Da	te signed (Month	
			> Than 7	Kan				04	1213			5/31/.	08
	3		30. Name and address of person who o										
		(SEE)	Ravi Yalamanchil	- 1			ohnson	Driv	e, Fre	derick,	MD	21702	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 2 2	005 32. Segistrar	's Signat	ture	San Aller						

			1 - State Registrar	State of I	Maryland /		artment <i>tificate</i>			nd M		giene		98	52
			Decedent's Name (First, Middle, Last,								2. Date of De	ath		3. Time of	Death
	Physici /Medio		Cla	ra Louis	e Pyles						Month May	30	2005		р м
	Examir		4a. Facility Name (If not institution, give	street and number	er)		4b. City, T	Town, or	Location of	f Death		4c.	County of De	ath	
			Deer Ridge Manor:	1126 R	idge Roa	.d	:	Risi	ng St	ın			C	ecil	
	Funeral Director		5. Social Security Number 6. Sec 213-40-1442	7.]M 2⊠F	Age (In yrs. last 65	birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da OCt.	y, Year)		irthplace (State of Country)	r Foreign
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, To		anties							Taga Innida Oil	
	anyla shon	2			Toc. City, Te	JWII OI LO		_						10d. Inside Cit	•
	he M	Director	Maryland Ceci 10e. Street and Number	<u> </u>					posit			10 - Citi	zen of What 0		
	a or	급	27 Lagoon Drive				10f. Zip (Code	2190	1		rog. Citi	U.S	,	
	eath	eral	· · · · · · · · · · · · · · · · · · ·	12. Was Decede	nt Ever in U.S.	13.1	Was Decede	ent of His			cify Yes or No	h-		nerican Indian,	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23s or 28e-f show marked other than "natural", or Items 23s or 28e-f show marked other than "natural".	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	s? XINo	1	f Yes, speci		Specify:	Puerto F	cify Yes or No Rican, etc.)		Black, Wh		
21215-0036	2 hou		15. Decedent's Edu		16	Sa. Dece	ent's Usual	Occupa	tion	-4			nd of Busines		
215	within 7 ene. than "n	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4)	or 5+)	life. I	kind of work DO NOT use	e retired)	uring most	or workir	19	Hate	m Memo	rial Bri	.dge
2	filed will Hygien other than	Completed	Twelve Years				Toll	Coll	ector	2		Perr	yville	, Maryla	nd
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle				
Σ	Men Men arke	ို	George Her								R. Ann				
Maryland	as 1 and 2 should b of Health and Ment item 27 is marked r other treumatic a		19a. Informant's Name/Relationship (Ty								Route Numb			Zip Code)	
	1 and Health am 27		Mildred D. Jones 20a. Method of Disposition	(sister			sition (Name	•	EIKC	-	Marylan ate		21921	or Town, State	
و	Pages ment of H ant: If its ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	temoval from Sta	te ceme	itery, crer	natory or oth	her place	·		03/05				m.: a
Baltimore,	ir. Partmen		4 ☐ Donation 5 ☐ Other (Specify)21. Signative of Funeral Service Licens		FOIL		y Cem		7		03/03	FOLU	ASHOY,	West Virgi	ша
Ba	permit. Page Department of Important: If any injury or once.		Montes he	CHE	Jan City	· Pe	ee A. erryvi	Patt .lle	erson Mary	n & ; ylan		903-0		P.A.	
п			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caus ne cause on each	sed the death. D	o not ent	er the mode	of dying	, such as o	ardiac o	r respiratory a	rrest,		Approximate Interval Bety Onset and D	ween
	Pnysician	Žψ	Immediate Cause (Final disease or condition	- Co	Loseco	2 orl	Co	46	1					Offiser and L	real!!
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	ce of):									
		<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequenc	se off:		_						-	
	ted nsit	nin	cause. Enter Underlying Cause (Ulsease or injury that initiated events	Duo to (or	ao a consoquent	30 01/.									
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or	as a consequenc	ce of):						-			
8760,	siciar b buri	dicalE		+											
89	ificate g phy as the			4.											
O. Box	at the death certifi by the attending I tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal dea at time of death		Ectopic pre Other (spe					2	23d. Date of de Month		'ear
صِ	that ned by deta		Part II. Other significant conditions con	ntributing to deat	but not resulting	g in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco u	se contribute	to the cause of de	eath?
rds	quires n sign	d by						_			1 🗆 '	Yes 2.5	₹ No 3□F	Probably 4 □U	nknown
Records,	The law requires that ite has been signed b page 2 should be deta	Completed									24a. Was			autopsy findings a completion of ca	
a											1 Tes	2 🔀 No	1 ☐ Ye	s 2 No	
Vital	Physicien: This certificate al director, p	o Be	25. Was case referred to medical examiner?	fospital:		0.4								iving Faci	lity-
of		P-14	1 Yes 2 No	28a. Date of I	atient 2 ER/	outpatien o. Time of		c. Injury	4 1401		ne 5 Resident			ecify)	
on	ding I th. : After s funer	tlor	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	м	Work	? 'es 2∐N						
Division	or Attending after death. Director: Afte in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At home,	farm, str	eet, factory,	office		2				Rural Route Numb	be <i>r</i> ,
Ö		Cert	4 Homicide	building,	etc. (Specify)						City or To	wn, State)			
	To the Hospitel or within 24 hours after To the Funeral Dirtement of completely filled in I	edical (29a. Certifier 1 ☑ Certifying Phy (Check only one)	sician: To the be ner: On the basis and manner	of examination	ige, death and/or in	occurred a vestigation, i	it the time	e, date and inion, death	l place, a h occurre	nd due to the id at the time,	cause(s) date and	and manner a place, and du	as stated. se to the cause(s)	1
	To the I within 24 To the I complet	Me	29b. Signature and title of certifier				29c.	License	number					nth, Day, Year)	
			· //	X K	1)3	30	99	7	Mai	131	,200	5
	K		30. Name and a ress of pers n o co							-			/	/ E	
			Promila Suri, M.D.	, 155 W	est High	Str	eet,	Elkt	on, M	laryl	and 2	1921			
	Sta		31. Date filed (Month, Day, Year)		strar's Signature		,								
	Registi	ar	MAY 3 1 2005	Been	JE A	podl	<u>ر</u>								

Physician Compared to Name Last Element on Physician Element				State of Maryland / Depart State of Maryland / Depart Certi		
Taylor Me If a House Fundament of the Search of the House Fundament of the Search of the House Fundament of the House Fund		Physici	an		2. Da	te of Death 3. Time of Death
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Social Service Number Soci		Examin	ier		_	, , , , , ,
Use A membrane of December 100 City, Team of Localism 100 City, Team				5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. (Mo	te of Birth onth, Day, Year) 9. Birthplace (State or Foreign Country)
The part of the pa		D.		Usual Residence of Decedent		
The part of the pa		Aarylar f show	ō		lion	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
The part of the pa		or 28a-	lrect		10f. Zip Code	10g. Citizen of What Country?
The part of the pa		s 23a c	eral D			United States of
Part College	036	urs aftar de el', or Item	þ	1 Never Married 2 Married 1 Yes 2 No		Specify:
15. Nother's Name (Final, Michole, Later) 16. Louis Pischke 17. Fasher's Name (Final, Michole, Later) 18. Indoman's Name-Relationship (Final, Michole, Later) 18. Indoman's Name-Relationship (Final, Michole, Mary Call	1215-0	vithin 72 ho ne. hen "netur e Madical	mpleted	(Specify only highest grade completed) (Give kin	nd of work done during most of working	
Lowell Plischke Lowell	d 2	filed w Hygier other tl				
20. Plane of Deposition (Party	ylan			Louis Plischke	Louise F	Peterleus
20. Nemoto of Disposition 20	Mar	2 2 2 2				
23a Part. Enter the display, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart family. List only one cause on each rine. Immediate Causer Ginal Final Feather and Control Final Feather and	Jore,	90 = 5		20a. Method of Disposition 1 Burial 2 Femalion 3 Removal from State 20b. Place of Disposition cemetary, crema in Conference in	ion (Name of Date tory or other place)	20c. Location - City or Town, State
23a Part. Enter the display, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart family. List only one cause on each rine. Immediate Causer Ginal Final Feather and Control Final Feather and	altin	mit. Paramer partmer portent / injury		Pennsylvar	nia [–] 6/4/2005	
Proyection Model Call Examing in death) Sequentially list conditions, sausial first distance or condition from the condition of the condition	ñ	e la la la la la la la la la la la la la		12	South Second Street	Denton Maryland 21629
Due to (or as a consequence of): Due to (or as a consequence of):				Immediate Cause (Final disease or condition resulting in death)		Onset and Death
Second S			miner	Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
The part of the pa	∞	cate be exec ohysician an the burial-tr	cal			
The part of the significant contributing to death out to residing in the dinderlying class given in part. 1 Yes 2 No 3 Probably 4 Unknow	. Box	death certif e attending id for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ec		
25. Was case reterred to medical examiner? 10 yes 2 No 25. Was case reterred to medical examiner? 10 yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 28. Date of Injury (Month, Day, Year) 29. Certifier (Check only one) 29. Certifier (Check only one) 29. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature		quires that en signed b	by	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I. 23	
26. Place of Death (Check only one) 27. Manner of Death 1			Complet			autopsy prior to completion of cause of death?
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 4 Work? 4 Homicide 29a. Certifier (Check only on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comprises table of Park Pen Plan Ton MD 21629 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		sician: certific irector.	Be	examiner?	Other	175515 (EV)
State State Pacification Paci		<u>a</u> ≠ <u>a</u>	H	27. Manner of Death 28a. Date of Injury 28b. Time of		
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and marrier state. 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hospital 4 hours a Funerel C ely filled		(Check only 2 Medical Examiner: On the basis of examination and/or invest		
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State Registrar State Registrar State Registrar State Registrar State Registrar State Registrar State Registrar State Registrar Signature)	-> H 0		Christian Gentren III	D14664	
Bolistrar				C.E. JOUSENIND OB #690	DENTON MD	21629
11N = 6 2005 Bugue B		Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A)	

			For State Registrar	State of Maryla		partment of Fertificate of			ene 0 0 E	19854
	Dhuaiai	200	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Emma	Louise	P	hillips		June	6 20	
	Examin	er	4a. Facility Name (If not institution, g		t - 1	4b. City, Town, o	or Location of Deat	h	4c. County of	Death derick
			Frederick Mem 5. Social Security Number 6.		rs. last birthda			. 8 Date of Birth		
	Funeral Director		217-28-5121	4 CIM 200 E	72 Yrs.	Months Days	Hours Min.		Year) 1932 V	9. Birthplace (State or Foreign Country) /irginia
			Usual Residence of Decedent					, our, ,,	1752 , ,	
	inylan show	<u>.</u>	10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 X No
	8e-1	Director	Maryland Frederic	k Fr	ederic			10	a Chiana at Mh	
	with the		10e. Street and Number			10f. Zip Code			g. Citizen of Wh	at Country?
	eath 1	eral	5717 Shaw Drive	12. Was Decedent Ever in	n U.S. 13	21704 3. Was Decedent of F	Hispanic Origin? (S	US Specify Yes or No-		American Indian,
10	fter d	Funeral	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ☐ Yes 2 XNo		If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		White, etc.
036	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
2-0	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Itams 23a or 28e-f show ther than "natural", or Itams or 28e-f show ont. The Medical Examinari out to indiffed at	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Gi	edent's Usual Occup ve kind of work done	during most of wo	rking	6b. Kind of Busi	iness/Industry
121	vithin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		. DO NOT use retire	d)	_	1	
2	filed withi Hygiene. other than		17. Father's Name (First, Middle, Las	it)	nome	naker	18. Mother's Na	me (First, Middle, M.	wn home aiden Sumame)	
Maryland 21215-0036	e d fall be	o Be	Harvey Rollins Ba				Emma Rob	erta Cole		
Ž	2 should I and Men is marka eumatic	2	19a. Informant's Name/Relationship		19b. Ma	iling Address (Street		ural Route Number,		tate, Zip Code)
	ad 2 lith a 27 is r tre		Kathy Miss, daugh	ter	731.	01d Midd	lletown R	load, Midd	letown,	MD 21769
ře,	of Heal	1 8	20a. Method of Disposition	20	b. Place of Dis	position (Name of rematory or other pla	(ce) 6/1	Date 0/2005	0c. Location - C	ity or Town, State
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 🛣 Other (Spec		Resthav	en Memori	al Garden		rederic	k, Maryland
alt	permit. Pag Department Importent: I eny injury c		21. Sonature of Funeral Service Lic	ensee		22. Name and Addre	ess of Facility K	leeney and	Basfor	d Funeral Home
<u> </u>	20599		Kyan M.					treet, Fr		
г			23a. Part1. Ener the disease, or co shock, or heart failure. List on	y one cause on each line.				c or respiratory arres	St,	Approximate Interval Between Onset and Death
	Physician		Immediate Sause (Final disease or condition resulting in death)	a	ro vas(uli	ir Acciden	t			
	/Medical Examiner		1	Due to (or as a con	sequence of):					
		ē.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a con	sequence of):					
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0						
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a con	sequence of):					
68760,	ate be shysici the bu	ical		d						
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		3 □Ectopic pregnanc			23d. Date	of delivery
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)			Monti	h Day Year
P.0	that the de ned by the a detached f	Phys	9 Unknown		W		a la Dual	000 Did tobe	anna una contrib	oute to the cause of death?
Records,	uires tha signed Id be de	by	Part II. Other significant conditions I q A Mycloma	contributing to death but not	resulting in the	underlying cause gr	ven in Part I.	1 ☐ Yes	1	Probably 4 Unknown
00	w requir	Completed	Cardiomyo	pathy				24a. Was an	24b. We	ere autopsy findings available
Re	he la e has age 2	dwo	Carolina					autopsy perform 1 Yes 2	ed? de	or to completion of cause of ath? Yes 2 No
Vital		a)	25. Was case referred to medical				26. Place of De	eath (Check only one		1.63 ZU.140
Į	Physicien: this certificatal director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpat	ient 3 DOA Ot	her: 4 🗌 Nursing I	Home 5 Resider	nce 6 Other	(Specify)
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injur	y Wo		28d. Describe how	w injury occurred	d
sio	Attendia death. ctor: A y the fu	catl	2 Accident investigat 3 Suicide 6 Could not	ha			Yes 2 No	206 1		and Control Control
Division	or At ifter d Direct in by	Certification;	4 Homicide determine		At home, farm, pecify)	street, factory, office		City or Town,	State)	r or Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune			Physician: To the best of my aminer: On the basis of exam						
	the H lin 24 the F	Medical	one)	and manner stated.						
	To with com	2	29b. Signature and title of certifier				05579		d. Date signed ((Month, Day, Year)
7			STUMM, M.I) .	,,		١١ردن		6 6	100
	4		30. Name and address of person wh	o completed cause of death (rederick M	emorial F	tospital		
	St	ate	31. Date filed (Month, Day, Year)	32. Résistrar's S		- Carbon (a. g		7 7		
	Regist		JUN 1 3	2005	K	Societies.				
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			1 - For State Ragistrar	State of M	laryland /		rtment <i>tificate</i>			nd Mer	ntal Hy	giene Reg. No	000	19855
I	Physic	an	1. Decedent's Name (First, Middle, L	ast)							Date of De	aath Da	y Year	3. Time of Death
	/Medi				Ribot					Ma	y 23			12:59 a ^M
4	Examir	ner	4a. Facility Name (If not institution, g				•		Location of	Death			County of Dea	
	Euparal		Southern Maryla 5. Social Security Number 6.		a⊥ ge (In yrs. last I	birthday)	If Under 1	ntor Year	1 If Under 2	4 Hrs. 8	Date of Bi		rince G	eorges
	Funeral Director		584-50-9213	1□M 20F	73	Yrs.		Days	Hours	Min.	Month, Da	ay, Year)	C	nican Republ
	p		Usual Residence of Decedent 10a, State 10b, County		40- Ch. T.					1110	.,	, 17	32 BOM1	•
	ours after death with the Marylan rat', or Items 23a or 28a-f show Examiner must be notified at	ō	, , , , , , , , , , , , , , , , , , , ,	Georges	10c. City, To		rille							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-1	Director	10e. Street and Number		101		10f. Zip C	ode				10° Cit	izen of What C	
	3a or		7316 Leona Stre	a+				747						ountry :
	death ms 2	Funeral	11. Marital Status	12. Was Deceden		13. V	Vas Decede	nt of His	panic Origi	in? (Specify	Yes or No		n. Rep. 14. Race - Am	
98	after or Ite	/Fu	1 ☐ Never Married 2 ☑ Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give			Yes, specif		Specify:	Domini	.can		Black, Whi	
8	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates					Re	epubli			Specify: Hi	
15	within 72 l ene. than "nat	Completed	15. Decedent's (Specify only highest g		16	a. Deced (Give I life. F	ent's Usual kind of work OO NOT use	Occupat done du retired)	tion uring most o	of working		16b. K	ind of Business	/Industry
212	e filed within Il Hygiene. other than vent, Ine M	omp	Elementary/Secondary (0-12)	College (1-4o	5+)		sekee					Dor	nestic	
Maryland 21215-0036	be filed within 72 ho ital Hygiene. id other than "natui event, ine Modical	BeC	17. Father's Name (First, Middle, Las	it)					18. Mother	s Name (Fil	st, Middle	, Maiden	Sumame)	
<u>yla</u>	2 should be and Mental is marked o	To	Anbrosio Betance	s					Mari	ia Nun	ez			
Jar	2 short and last m		19a. Informant's Name/Relationship	(Type, Print)	19								r Town, State,	
e,	1 and 2 fealth and 27 i		Juan Nunez /Son 20a. Method of Disposition		20h Place		Leon		reet	Fores	tvil.			747
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: if Item 27 is marke any injury or other treumatic. 00ce.		1 Burial 2 ☐ Cremation 3		cemet	ery, crem	atory or oth	er place	1				ocation - City or	
Ē	artme orteni injury		' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Resu		tion Name and	Address		ay 26,	2005	C1:	inton,	Md.
Ba	permit. Departn Importe any inju		PROTO	.~. M1	11195	5	1exan	der arIb	S. Pc	Pre-Fu	nera	l Hor	nes, Md:	A. 20747
	- 01		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cause	d the death. Do								,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, 0110 00000 011 00001	NEUT									Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence									2 PK/3
	Examiner	_	Sequentially list conditions,	b										
	bed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	e of):								
	al-tra	xan	that initiated events resulting in death) Last	c. Due to (or a	s a consequence	e of):	_						_	
8760,	cate be executed physician and the burial-transit	dlcal E		d										
9	tificat ng phy as th	ledi		_ 0.								- ,		
Вох	death certifi e attending p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal deat	th 3□	Ectopic preg	nancy				2	23d. Date of de	
о. П	e death the atte	sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		at time of death		Other (spec						Month	Day Year
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COL	w requir	lete	MYS LOPROL	IFERATI			12 DE			_	24a. Was	-		
Vital Records	The tav	Completed	DIABETES	MELLI		_	2 -T	_			autor		prior to death?	itopsy findings available completion of cause of
ta Ta	ician: Th certificate rector, pag	(I)	25. Was case referred to medical	19(8,00)	14.2	1 / /	را- ع		26 Place o	of Death (Ch			1 🗆 Yes	2 No
	y si	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2 ER/C	Outpatient	3□ DOA	Other					Other (Spe	cify)
0	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b.	Time of Injury	280	Injury a	at	-			occurred	
sió	tendi leath. Ior: A the fu	catle	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	ne -			М		es 2□No					
División of	or At after d Direct in by	Certification;	4 Homicide determine	ZOO. FIACE OF IT	ijury - At home, f tc. <i>(Specify)</i>	farm, stre	et, factory, c	ffice		28f. L	ocation (S City or Tox	Street and vn. State	d Number or Ru)	ıral Route Number,
	spital ours a leral l		29a. Certifier 157 Cartifying P	hysician: To the bes	of my knowledg	ne death	occurred at	the time	date and	place, and a	lue to the	021100/51		- stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Madical Exa	minar: On the basis and manner s	of examination a	nd/or inve	estigation, in	my opi	nion, death	occurred at	the time,	date and	place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	An.			-	icense i					e signed (Monta	
}			1 (New Ka	ya 1	10		1)	00	0616	52	_	MA	Y, 24	14, 2005
	(1)		30. Name and address of person who				rint)							
			31. Date filed (Month, Day, Year)	ATAWAY		ン	# '	5 0	,	イニュー	TON		113 2	-0155
	Sta Registr		JUN 0 1 200		rar's Signature.	hose	B							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 2^{Day} **Physician** LILLIAN M. RINGGOLD 2005 7:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 18 ASBURY ROAD CHURCHVILLE HARFORD 8. Date of Birth (Month, Day, Year) June 14, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 X F 88 215-44-0949 Yrs 1916 Director New York Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow r than "natural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Harford Directo Churchville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18 Asbury Road 21028 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ŽÑNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>ک</u> Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Domestic Private Homes . Pages 1 and 2 should be filed w tment of Heelth end Mental Hygier tant: If item 27 is marked other th jury or other traumatic syent, IL. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Bond Etta Smith ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda R. Harris / daughter 18 Asbury Road, Churchville, Maryland 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State John Wesley United Cem * 4 ☐ Donation 5 ☐ Other (Specify) 6/2/05 Abingdon, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility disa Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, -) cett MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OF The months CarcINOMA /Medical Due to (or as a consequence of): Examiner Social to the second that it is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien end for use es the burial-transit The law requires that the death certificete be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the e d be deteched t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy performed? 1 ☐ Yes 1 Yes 2 No 2 3 No Hospitel or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 PNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number N. dela lant May 29, 2605 014036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rene P. de (09 5A 11765, 12 2835 CHURCH UILLE ROad, CHURCHUILL, Waryland 21028 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [19857 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) $20\overset{\text{Year}}{05}$ Physician 3Ŏ MAY 1609 SKEANS CHARLES ROBERT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Examiner KENT CHESTERTOWN CHESTER RIVER HOSPITAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F APRIL 23, 1949 MARYLAND 217-52-3865 Director 56 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No SUDLERSVILLE QUEEN ANNE'S Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1330 SUDLERSVILLE ROAD USA 21668 Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2XNo 1 Never Married 2 Marned WHITE 1 ☐ Yes 2X No Specify. Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICAL UTILITES LINEMAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES ROBERT SKEANS MILDRED HANNAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1330 SUDLERSVILLE ROAD, SUDLERSVILLE, MD 21668 MARGARET F. SKEANS/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SUDLERSVILLE CEMETERY JUNE 4, 2005 SUDLERSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature/of Funeral Service L FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Thomas Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SMOKING Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed HYPERTENSION the attending physicien and Due to (or as a consequence of) Physician/Medical HYPERLIPIDEMDA IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed δ page 2 should be 3 Probably 4 Unknown 1 X Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 X No certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 😿 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death 2 Accident after death Director: 6 Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel or 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D35048 5/31/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

32. Registers Signature 31. Date filed (Month, Day, Year) 2005

Division of Vital Records, P.O. Box 68760

ERIC R. CIGANEK, M.D., 2540 CENTREVILLE ROAD, CENTREVILLE, MD 21617

		_	State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N Par ME 5349 11/21/05d Registrar	lental Hyg l hb	giene 005	19859
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath Day Year	3. Time of Death
	Physicia /Medic	_	LEONARD W. SNIVELY	June	07 2005	22:26M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
			The Johns Hopkins Hospital Buttimer City	/	Baltimo	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs./ Months Days Hours Min.	8. Date of Birt (Month, Da	h 9. Birt y, Year) Co	hplace (State or Foreign untry)
	Director		200–22–5119	Dec 1,	1927 F	'A
	pu s	-	Usual Residence of Decedent 10a, State 10b, County 10c. City, Town or Location			10d. Inside City Limits
	sho	5	PA Franklin Waynesboro			1 ☐Yes 2X No
	28e-1	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	Mith With	ā	358 Geiser Avenue 17268		USA	
	leath	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or items 23s or 28e-f show event, Its Medical Examinar in that be mailfied at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerio 1 Yes, Give 1 Yes, Give 1 Yes 2 No Specify:	Rican, etc.)	_	white
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lan			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			Zip Code)
	os 1 and 2 of Health item 27 I		Esther L. Snively wife 358 Geiser Ave. Wayne	esporo,		Town State
Baltimore,	ges 1 of H if ite		1 Thursday of Other place)		20c. Location - City or Washington	TWP
Ë	permit. Pages Department of I Important: If ite any injury or of		'4 □Donation 5 □Other (Specify) Antietam Cemetery Jun	10 2005	Franklin C	0. PA
3aH	Depart Import any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gro			
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			23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition as PULMONARY EMBOLISM	-0	1	7- hours
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1 1/		1
	-Adminio.	er	Sequentially list conditions, if any leading to immediate b. C4, C5, T12, L3 Fractures Due to (or as a consequence of):	1///		
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	and al-trar	Examin	that initiated events c	7 W	BYMEDICALE	
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687	death certificate be executed e attending physician and od for use as the burial-transit	edical	GEN			
) XO	ath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	ivery
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ecord	w requ	jete		24a. Was		itopsy findings available
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Vital		C	25. Was case referred to medical 26. Place of Deat	th (Check only o		20110
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lon	nding l tth. : After e funer	atio	Natural 5 □ Pending (Month, Day Year) Injury Work? 1 □ Yes	fell dov	vn basement	stairs
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Ö	s efte	Sert		the same same		aynesboro, PA
	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune.	edical (29a. Certifier (Check only one) Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	h, Day, Year)
	P S P Ö		Lunei MESimmon, M.D. RES-00	0	6/7/200	3
			30. Name and address of person — completed cause of death (Item 23a) (Type, Print)			
	1		LUNEI FITZSIMMONS 600 N. WOLFE ST. BALTIMORE	MD 2.	1287	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2005 32. Degistrar's Signature		-	

			For Stete Registrar	State of N	Maryland / Depa Cer	artment of Hertificate of L			giệne) () 5	19860
	Physici	an	1. Decedent's Name (First, Middle, La. ESTELLE	SHA	NK			2. Date of Dea Month JUNE		3. Time of Death 2:05P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and numbe	or)	4b. City, Town, or FREDERI			4c. County of Death	.
	Funeral Director		5. Social Security Number 6. S 220-09-8066	ex 7.7	Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth April 1		place (State or Foreign intry) aryland
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Freder	ick	10c. City, Town or Lo Frederi					10d. Inside City Limits Y Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 700 Toll House	Ave.		10f. Zip Code 21	701	1	U.S.A.	intry?
036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, I're Midical Exertil et mast be mullind at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	i No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	, etc.
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Maryland	C1 62 50 60		19a. Informant's Name/Relationship (Charles S. Picke						r, City or Town, State, Zi erick, MD 21	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. 2002		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)		20b. Place of Dispo	esition (Name of matory or other place et Cemetery	June 11,	Date 2005	20c. Location - City or T Frederick,	
Balt	permit. Departr Imports any inj		21. Signature of Funaral Service Licer	Jyy C	MOO255 1	^{2. Na} Reend Address 06 East C	and Basf hurch St	ord PA F	Tuneral Home erick, MD 21	701
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.O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Year
Records, P.	v requires been signi should be	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the un	nderlying cause give	n in Part I.	23e. Did tol		the cause of death? bably 4 □Unknown opsy findings available
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Divi	tal or Attences after death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	288. Place of	Injury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (St City or Town	treet and Number or Run n, State)	al Route Number,
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	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	ah	softher.	29c. License	number S	3	9d. Date signed (Month,	Day, Year)
	2		30. Name and address of person who	somple ed cause o	of death (Item 23a) (Type,	Print)	the cot	Frank	prick 1	nD
	Sta Registr		31. Date filed (Month, Day, Year) JUN I 4 2	005 32 legis	strar's Signature	ente				

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	9		Decedent's Name (First, Midd	lle, Lasi	1)							2. Date of Dea	ath			3. Time of Death
	Physici		Marie S. Schi	ff								Month May 20	Da	2005 Year		12:40 P ^M
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	- Examin		Collingswood Nursing Center Rockville								M	ontgome	rv			
	Funeral		5. Social Security Number	6. Se	x		yrs. last birthday,	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da				e (State or Foreign
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	pue *		Usual Residence of Decedent 10a. State 10b. Count	,		10c	City, Town or L	ocation							10d	. Inside City Limits
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	with Se or	Funeral Director	299 Hurley Ave	nue					0850					.S.A.	, , , , , ,	
	Jeath Jeath	era	11. Marital Status	IIde	12. Was Dece	edent Ever i	n U.S. 13.			ispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)		14. Race - An	nencan	Indian,
(0	or Iter	Fun	1 ☐ Never Married 2 ☐ Ma	rried	Armed Fo 1 ☐ Yes	2 💢 No						Rican, etc.)		Black, Wh	nite, etc	.
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<u>o</u>	Pages nent of Pages of Pages		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (3 □I	Removal from	State	cemetery, cre t. Linc			,	05/2	1/2005				
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Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic events.		Kon yem	da	L. Thom	VI.						-			1an	d 20852
			23a Part1. Enter the disease of	rcomp	lications that c	aused the c									A	pproximate
B	Pnysician		shock, or heart failure. Lis Immediate Cause (Final	t only c	one cause on e	add line.	him	Dr.	01.0							nterval Between
	/Medical		disease or condition resulting in death)		a. Due to	r as a con	sequence of):	1010	_(()	mo	116		-5	-	210	W.
	Examiner		Conventially list and disease		b. Ch	son	ic /	756	360	chiv	e	unge	dis	ease.		
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	Due to	or as a con	sequence of):		-	1 - 1 19						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c. //	ues	OSCLE	208	15 /	hec	586	dise	W	20:	1	
760,	ate be executed hysician and he burial-transit	E	rooming in county much		Due to	or as a con	sequence of):									
687	physic the b	dical		0	d										-	
9 ×	ding se as	/Me	IF FEMALE:		23c. If yes, out	come of pre	annancy							201 0-11-11		
Вох	leath certificat attending phy I for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?		1 ☐ Live b	irth 2 ☐ F ant at time	etal death 3	☐Ectopic pr☐Other (sp						23d. Date of d Month	Da	ay Year
o.	t the de by the a tached	ıysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		9□ Unkno				,,							
Δ.	that ned b		Part II. Other significant condit	ions co	ntributing to de	ath but not	resulting in the t	nderlying c	ause givi	en in Part I	1.	23e. Did to	bacco	use contribute	to the	cause of death?
rds	n signi	d be	Cerebro	Ma	Sail	08	accio	leal				1 🗆 1	es 2	!□No 3□F	Probab	ly 4 ⊠Unknown
Records,	s been s been s should	ojet	49									24a. Was				y findings available
Re	The law requires that the death certifica tale has been signed by the attending phage 2 should be detached for use as It	Completed by										autop perfo 1 Tyes	rmed?	death?	comp s 2	letion of cause of
Vital		a)	25. Was case referred to medic	al						26. Place	e of Deat	n (Check only o		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
f <	S S	To B	examiner? 1 ☐ Yes 2 🛣 No		Hospital: 1 □ I	npatient :	2 ER/Outpatie	nt 3 DC	Oth			me 5 Resid		6 □Other (Sp	ecify)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 ★Natural 5 ☐ Pend	ina	28a. Date	of Injury h, Day Yea	r) 28b. Time o	if 2	8c. injun Worl	at k?		28d. Describe h				
<u>S</u>		cati	2 Accident inves	tigation				М	1 🗆 '	Yes 2	No					
Division	l or Attendater deatl Director:	Certification:		mined	28e. Place buildi	of I <i>n</i> jury - A ng, etc. (<i>Sp</i>	At home, farm, st ecify)	reet, factory	, office			28f. Location (S City or Tox			Rural F	Route Number,
	urs a		200 Contilion 15W Continu	no Dhi	roleine. To the	h t - f	to a suite de la colonia				1 1					
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyi (Check only 2 Medica	I Exam	iner: On the bi	best of my asis of exan her stated.	knowledge, dea nination and/or in	n occurred vestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the core and at the time,	cause(s date an	 and manner a d place, and du 	as state ue to th	ed. le cause(s)
	o the o the omple	Me	29b. Signature and title of certifi	er /	7 -	ior otatos.		290	. License	a number			29d. Da	ate signed (Mor	nth, Da	y, Year)
			* Kaman	R	- 7 cm	li-		12	196	09			5.5	26.05		
	12		30. Name and address of person	n who c	ompleted caus	e of death ((Item 23a) (Type	Print)	2An	1AN	R	· TOUL	M	1)		
			30. Name and address of person 10810 DARN (31. Date filed (Month, Day, Year MAY 31	ES	TOWN	1 P	DAD. S	UITE	20	2, /	AIT	HEDS	BU	RG. M	1) 5	20878
	Sta	ite	31. Date filed (Month, Day, Year)	33. R	egistrar's S	ignature	40 -		164		the stand			, ,	
Ó:	Registr	ar	MAY 3 1	200	15 KA	180 J	15. ADO	ACR.								

DHMH 17 Rev 1/2001

			State of Maryland / [State of Maryland / [Registrar	Department of H Certificate of I		lental Hygie	CUUN	19862				
١	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joseph T. Smith			2. Date of Death Month May 28,	Day Year 2005	3. Time of Death 9:56 P M				
ŧ	Examin		4a. Facility Name (If not institution, give street and number) Renaissance Garden at Riderwood Vi		Location of Death		4c. County of Deat Prince Geor					
	Funeral Director		2,0 20 3000	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye June 6,	9. Birti Co 1927 Penn	hplace (State or Foreign untry) sylvania				
	aryland show	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Prince George's Silve	n or Location er Spring				10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	r 28a-f	irect	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co					
	ath wit	alD	3160 Gracefield Road	2090)4		USA					
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other Hygiene. Is marked other than "natural; or Items 23e or 28e-f show aumetic event, the Medical Examiner must be notified a	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.				
21215-0036	within 72 ho ene. than "natur he wedical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired Engineer	during most of worki	ng	. Kind of Business/ General E	·				
_	0 - 0 2	To Be Co	17. Father's Name (First, Middle, Last) John P. Smith			(First, Middle, Mail						
Mary	nd 2 shoulth and N			. Mailing Address <i>(Street a</i>			-					
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumetic avonce.		20a. Method of Disposition 1 X Burial 2 Communication 3 Removal from State 20b. Place of cemeter	Disposition (Name of ry, crematory or other place epulchre Cemete	June June	2)ate 200	. Location - City or	Town, State				
Balti	permit. Departm Importa any inju		21. Signature of Juneral Service Licepses	Fightisand Address 500 Universit	Milifis ⁱⁱ Funer y Blvd, W.,	al Home Inc						
	Physician		23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Dementia									
Ŀ	/Medical Examiner		Failure To Thrive	of):				3 Months				
	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
8760,	icate be executed physician and s the burial-transit	edical Ex	Due to (or as a consequence d.	of):								
.O. Box 6	death certif e attending id for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown			23d. Date of delivery Month Day Year						
ds, P.	uires that t signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in	buting to death but not resulting in the underlying cause given in Part I.				the cause of death?				
Records,	The taw requires that the ate has been signed by the page 2 should be detached.	Completed				24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of				
	10	Be C	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	140	2010				
Division of V	ding Phys h. After this funeral dia	4	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou 27. Manner of Death	Fime of 28c. Injury	er: 4 Nursing Ho	me 5 Residence 28d. Describe how i		cify)				
=	in the	Sertification	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (Stree City or Town, S		ral Route Number,				
	To tha Hospitel within 24 hours a To the Funeral C	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the tind d/or investigation, in my o	ne, date and place, pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)				
)	To the within Post	Me	29b. Signature and title of certifier Pullman	9, HD 29c. License	e number D59524	29d.	May 29, 200					
			30. Name and address of person who completed cause of death (Item 23a) Loveen J. Puthumana, M.D. 3110 Gracefiel	(Type, Print) d Road, Silver	Spring, MD	20904						
0.	Sta Registi		31. Date filed (Month, Day, Year) MAY 3 1 2005 32. degistrar's Signature	Aparli								

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			1 - For State Registrar	State of	f Marylan	-	irtment o tificate		alth and M eath		giene Reg. No	. 000	19863
	Dhysisi		1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Da	y Year	3. Time of Death
	Physici: /Medic		Nellie	Mar	tha	Shad	rick			May 2	5, 2	2005	4:00P M
	Examin	er	4a. Facility Name (If not institution, give s						cation of Death		4c	. County of Death	
			Civista Medic					lat				Charles	
	Funeral	i	5. Social Security Number 6. Sex	M 2⊠F	7. Age (In yrs. 73	last birthday)	If Under 1 Y		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthr	place (State or Foreign ntry)
	Director		577-42-5274 Usual Residence of Decedent		/)					12/04	/193	31 Wash	ington, DC
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	IOd. Inside City Limits
	Mary -fah	ō	MD Charle	3		Faulkn	er						1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number				10f. Zip Cod	de			10g. Cit	tizen of What Cour	ntry?
	h with		9240 Timbercreek	Lane				2	0632			U.S.A.	
	72 hours after death with the Maryland "netural", or Items 23a or 28a-f ahow dical Examiner must be notified at	Funerai	11. Marital Status	2. Was Dece Armed Fo	dent Ever in U	.S. 13. V	Vas Decedent	of Hispa	anic Origin? (Spe Mexican, Puerto	ecify Yes or No)-	14. Race - Americ	
٥	after or ite	T.	1 ☐ Never Married 2 ☐ Married	1 Tes	2 XNo		☐ Yes 2 🖾		Specify:	rsicari, etc.)		Black, White,	
215-0036	ours ral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:			140	,peeny.			Specify: W	hite
לַ	d within 72 ho piene. r than "natui ine Medical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	ent's Usual Oo kind of work de	one durir	n ng most of worki	ing	16b. K	(ind of Business/In	dustry
2	vithin ne. han	dm	Elementary/Secondary (0-12)	College (1	-4or 5+)		00 NOT use re Homemal					Own Home	
N	filed v Hygie other t		10 17. Father's Name (First, Middle, Last)				TOMEMAR		. Mother's Name	/First Middle			
Maryland	m - 0 W	Be	Jackson L. Mar	shall				, ,		E. Pen			
2	should be ad Menta marked matic ev	ဥ	19a. Informant's Name/Relationship (Typ	e. Print)		19b, Mailin	a Address (St	reet and				or Town, State, Zip	Code)
2	nd 2 s Ith ar 27 is r trau		Martha E. Gollahe:		ughter	1			reek Lai				0632
ā,	s 1 ar f Hea item other		20a. Method of Disposition		20b. F	Place of Dispos cemetery, cren	sition (Name o	f		Date		ocation · City or To	
Ë	Page: ent of nt: If i		1 ☐ Burial 2 ဩCremation 3 ☐ R	emoval from	State	ationa	-		v 6/1/	/2005	Fa	11s Chur	ch. VA
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Service License	•					/			ral Home	
ä	Per Deg		M				520 S.	Waol	hington	St., A	1exa	ndria, V	irginia 2231
	ES D		23a. Part1. Enter the disease, or companions, or heart failure. List only of	e cause on	aused the dea	Do not ente	er the mode of	dying, s	uch as cardiac o	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final			brain.	INKIN	1,					Onset and Death
	/Medical	resulting in death)					7	7	*				
	Examiner		Sequentially list conditions,	11112	ite mi	neard	ial 1	ya	uction				36 ms. yearo.
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×	leath certifi. attending I i for use as		IF FEMALE:	3c. If yes, out	come of pregna	ancy						23d. Date of delive	20/
ROX	death certif e attending ed for use a	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		irth 2 Feta ant at time of d		Ectopic pregn Other (specify					Month	Day Year
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or Vital Records,		BeC	25. Was case referred to medical					26	6. Place of Death		-4		
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	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe			
200	Attanding ar death. actor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be						2 □ No				11
DIVISION	or Ati fter d diract	Certification:	4 Homicide determined	28e. Place buildi	of Injury - At h ng, etc. (Specil	ome, farm, stre fy)	et, factory, of	ice		28f. Location (City or To		nd Number or Rura e)	il Route Number,
	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fo		29a. Certifier 1 Certifying Phys	ician: T- #	hast of musica	wiadaa daatt			data and sizes	and due to the	201:2-1) and man-	totod
	24 ho 24 ho Fun etely	Medicai	(Check only one)	er: On the b	asis of examination of stated.	ation and/or inv	estigation, in I	ny opini	on, death occurr	ed at the time,	date and	d place, and due to	tated. the cause(s)
	Fo the vithin Fo the comple	Me	29b. Signature and title of certifier	1			29c. Li	ense nu	ımber		29d. Da	te signed (Month,	Day, Year)
	->		* Gent Al MANA	2	-		D.	-464	.19		0.	5/25/0	5
)	(3)		30. Name in odress of person who co				Print)			4			
_			Charlene A Letch	ford,	MD 404	E. Cha	rles S	tree	t LaPla	ta, MD	2064	46	
1	Sta Registr		31, Date filed (Month, Day, Year)	22. R	egistrar's Signa	ature	. •						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0.51 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 30, 2005 **Physician** 12:45 AM Charlotte H. Swartz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Vindabona Nursing Home Braddock Heights Months Days Hours Min. July 28, 1915 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 035-03-7290 1 ☐ M 2 🕱 F 89 Rhode Island Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Experience. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 No Completed by Funeral Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 98 Kearney Court 21702 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Foods Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Godfrey Samuel Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Swartz/Son Frederick, MD 98 Kearney Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 06/02/05 Lincoln Park Cem. Warwick, RI * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 wher the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No the 9 Unknown signed by t Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as added.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16675 MAY 31, 2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn 21716 DRUNSWICK 31. Date filed (Month, Pay, Y State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. William T. Scharf Baltimore, Maryland 21215-0036

Physici /Medi Exami

Funeral Director

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	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.							
	State of Maryland / Department of Health and M	ental Hygiene	5 19865					
	1 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg. No.	3. Time of Death					
an	William Theodore Scharf, Sr.	Month Day Y	'ear					
al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	June 3 2C	109 1000					
er	-3 00 Each	Tali	i i					
_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.). Birthplace (State or Foreign Country)					
	216-24-1287 1M 2 F 75 Yrs. Months Days Hours Min.	(Month, Day, Year) Feb 25 1930 Ca	alifornia					
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
ō			1 ☐ Yes 2X No					
ect	Maryland Caroline Henderson 10e. Street and Number 10f. Zip Code	10g. Citizen of Wh						
	26531 Bee Tree Road 21640		at oddiny:					
era	11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Spe	U.S.A.	American Indian,					
Fun	1 Never Married 2 X Married 1 X Yes 2 No		White, etc.					
l by	1 3 ☐ Widowed 4 ☐ Divorced	Specify:	White					
etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	16b. Kind of Busi	ness/Industry					
Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5+)		nce industry					
ပ္ပိ		(First, Middle, Maiden Surname)						
To Be	Fred Scharf Lillian	L. Ziemer						
-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		ate, Zip Code)					
	Colleen Taylor Scharf/ wife 26531 Bee Tree Road He	nderson, Maryla	nd 21640					
		ate 20c. Location - Ci						
	'4 Donation 5 Other (Specify) Chesapeake Cremation June	5 2005 Cheste	r, Maryland					
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbe	in Funeral Home	. РА					
V 17	PO Box 160 Greensbor	o, Maryland 216	39					
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,	Approximate Interval Between Onset and Death					
	Immediate Cause (Final disease or condition resulting in death) a. Hemopty Sis		Minutes					
	Due to (or as a consequence of):		Months					
ē	Sequentially list conditions, if any, leading to immediate b. Lung Cance Y Due to (or las a consequence of):	MONTAS						
aminer	Cause (Disease or injury that initiated events							
Exa	resulting in death) Last Due to (or as a consequence of):							
cal	d							
Med	IE CEMALE:							
IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery								
Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Abrial fibrillation Due to (or as a consequence of): d. 23d. Date of delivery Month Day Yea 1 Yes 2 No 3 Probably 4 Unknown 23d. Date of delivery Month Day Yea 23d. Date of delivery Month Day Yea 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings averaging the prior to completion of cause prior to completion prior to completion of cause prior to completion prior to completion prior to completion prior to completion prior to completion prior to cause prior to cause prior to cause prior to cause prior to cause prio								
, Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?					
d by	Abrial fibrillation		Probably 4 □Unknown					
ete			re autopsy findings available					
d			or to completion of cause of					

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician /Medical Medical Certification: To Be Comp

2 Accident

27. Manner of Dear

24a. Was an	24b. Were autops
autopsy	prior to comp
performed?	death?
1 Yes 24 No	1 \(\sum \text{Yes} \) 27

	perfe	ormed?	death?				
	1 Tes	20 No	1 🗆 Yes	250No			
26. Place of Death (Check only one)							
r							

Но	spital: 1 🔀 npatient 2 🗆	ER/Outpatient	3 🗆 🗆	Other Other	4 🗌 Nursing	Home	5 Residence	6 Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury a Work?	at		Describe how inj	
1			М	1 🗆 Ye	s 2 No			

5 Pending investigation	(Month, Day Year)	Injury	М	Work?	2 🗌 No	200. Describe now injury decirred
6 Could not be						001 1 10 10 1

3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	Certifying Physician: To the best of my knowledge	, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Examiner: On the basis of examination and	for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
one)	and manner stated.	

29b. Signature and title of certifier	WD	29c. License number
19 Williams Charles and Man	. 9	1/0

29d. Date signed (Month, Day, Year) JUNE 4 2005

	_						
30. Name and address of person who co	de	eted cause of death (Item 23a) (Type, Print	1)				•
1-ce Kshmi Va	A.	id va nathan	2195	. Who	hinator	51.	SASTON

State Registrar

31. Date filed (Month, Day, Year)

JUN - 6 32. Registrar's Signature

		•	For State Registrar	State of Marylan	-	artment of F		ental Hy	giene Reg. No.	005	19866
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Do	eath Day	Year	3. Time of Death
	Physici: /Medic		Mary Josephine					00	08	05	CH:30M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	\ i	4b. City, Town, o	Location of Death	10	4c.	County of Death	O£ 1
			5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birthi	place (State or Foreign
	Funeral Director		,	M 20XF 49	Yrs.	Months Days	Hoters Min.	8. Date of Bi (Month, Di	ay, Year)	Cou	ntry)
	P _		Usual Residence of Decedent	140.00	-						
	anylar show	2	10a. State 10b. County	fineral	y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 3√☐ No
	the M	Director	10e. Street and Number	IIIICIAI	ne)	10f. Zip Code			10a Citi:	zen of What Cou	
	with Sa or	iDir	HC 84, Box 74			26726	5		-	S.A.	iniy:
	death	Funerai		2. Was Decedent Ever in U.	.S. 13. \		dispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or N		14. Race - Amen	
Maryland 21215-0036	within 72 hours after death with the Maryland piene. r than "naturel", or items 23a or 28e-f show It e Medical Exeminer must be notified at	by	1 Never Married 2 🔀 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ♣☐No If Yes, Give Year or Dates:		rYes, specify Cuba		lican, etc.)	1	Black, White, Specify: Whi	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	lent's Usual Occup	oation during most of workin	a	16b. Kir	nd of Business/In	dustry
2	within ene.	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	d)	3	.2		
2	I Hygie other t		17. Father's Name (First, Middle, Last)		rai	alegal	18. Mother's Name	(First. Middle	Lav		
lan	o d a D e	To Be	Antonio T. Spat	aro			Frances			,	
ary	s 1 and 2 should be f Health and Mental Item 27 is marked o other treumatic eve	F	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	g Address (Street	and Number or Rural	Route Numb	er, City or	Town, State, Zip	Code)
	1 and 2 a Health ar fem 27 is		James E. Smith				74, Key	ser,	WV 2	26726	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R	Billoval Ilolli State		sition (Name of natory or other place		ate	4.700	cation - City or To	own, State
Ī	nit. Partme		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			nas Cem. . Name and Addre	6/13/0 iss of Facility	5	Key	ser, WV	
Ba	permit. Departr Importe any inju		I the Read V	obseque		larkwood	l Funeral 1912, Ke	Home	, Ir	nc.	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	e cause in ach line. Due to (or as a conseq	h. Do not ent	er the mode of dyir	ng, such as ćardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death Uncornt
V	ited	Examiner	cause. Enter Underlying Cause (Disease or injury							-	
Ć	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	ate be hysicia ihe bur	cai									
9	ntifica ng ph as th	Medi	IF FEMALE:								
.O. Box	at the death certificate by the attending phys tached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	y		2	3d. Date of delive Month	ery Day Year
S, D	requires that the leen signed by th hould be detache	by Pi	Parvil. Other significant conditions con		ulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
ord	w require been sig should b		CAREGIONA OF	COL				10	Yes 2	3 □ Prol	oably 4 Unknown
Vital Records,	law as b	ompieted						24a. Was	psy	prior to co	opsy findings available impletion of cause of
= R	Th ate pag	Con						perf	ormed?	death? 1 ☐ Yes	2 🗌 No
Vita	Physicien; The this certificate ral director, page	Be	25. Was case referred to medical examiner?	ospital:		. acloom Ott	26. Place of Death				
ot		: To	1 ☐ Yes 2 € No 27. Manner of Death	28a. Date of Injury	ER/Outpatien	t 3 DOA	4 Nursing Hom	ie 5 □ Res 8d. Describe			(y)
on	Attending r death. ector: After by the funer	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No				
Division	I or Attendii after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office	2	8f. Location	(Street and wn, State)	d Number or Run	al Route Number,
	rs afte el Dir	Cert		Dunamy, out (open)							
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edicai		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the To the comp	Ň	29b. Signature and little of certifier	106		29c. Licens	se number			signed (Month,	
			1 Coser	WOU	49	DE	31875		R	DE 8	2005
	5		30. Name and address of person who co	mpleted cause of death (Item	70N C	Print)	umberla	10, N	000	11502	
	Sta		31. Date filed (Month, Day, Year) JUN 1 3 2	32. Figistrar's Signa	2. 4				6	•	
011	Registr IMH 17 Rev 1/2	-1	2014 1 3 2	JUS Blown.	D A						

In and In and Interest of Health and Mental Hyglene. In and Informatic and Interest of Hammar and Mental Hyglene. In and Informatic and Interest of Hammar and	MD Oe. Street and Numb 513 TAYLO 1. Marital Status 1 Never Married 3 Widowed 4 (Specify Elementary/Second 8 7. Father's Name (Fi WILLIAM D 19a. Informant's Nam PATRICIA Oa. Method of Dispos 1 Burial 2 W 4 Donation 5 21. Signature of Fune	ISE TURN of institution, give E WOODS (nber 6. Se. 94 10 ecedent Ob. County DORCHESTI Her RS ISLANI 1 2 Married Divorced 1 2 Married Divorced 1 2 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 3 Married 1 4 Married 1 5	ER Street and number CENTER OX 7. A OX 7. A OX 7. A OX 7. A OX 7. A ER D ROAD 12. Was Deceden Amed Forces 1	Age (In yrs. 81 10c. City TAY Int Ever in U. Solution of the control of the con	16a. Decer (Give life.) HOMEN 19b. Mailin 949 N Place of Dispo- smetery, cree SAPEAR TER, I	CAM If Under Months ISLAN 10f. Zi 21 Was Dect If Yes, specified of we be kind of we be be kind of we be be kind of we be be kind of we be	BRIDG or 1 Year Days D p Code 669 addent of His ecity Cubar 2 No ual Occupa ork done d. use retired) ss (Street a NS MI ame of other places EMATI and Address	spanic Origin' spanic Origin', Mexican, Pi Specify: ation uring most of 18. Mother's EMILY and Number of LL RD. 19. 106, s of Facility	Peath Hrs. 8. D. (A. MA) Peath R. (A. MA) Peath R. (A. MA) Peath Peath R. (A. MA)	t, Middle, Mater Number, 120 EMONT, 2005 S	DORI Year) 1924 g. Citizen of JSA 14. R Spec 6b. Kind of OWN 1 aiden Sum City or Tow VA Oc. Locatio	of What Countries of What Countries with the Business/Inc. HOME way, State, Zip 20135 on - City or To	can Indian, etc. HTE adustry
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miner	resulting in death)		2 400/	tric	can	cei							Onset and Dear
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urial-tra	l any, leading to imm cause. Enter Underly Cause (Disease or inj	ring lury	283 to (or a	is a consequ	dance or.								
.e a	that initiated events resulting in death) Las		Due to (or a	as a conseq	uence of):								
ng physicia s as the bur	IF FEMALE:		d										
the attend thed for us	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	onths?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant: 9 ☐ Unknown	2 Fetal	I death 3	⊒Ectopic (⊒ Other (s	pregnancy specify)			_		Date of delive Month	ery Day Year
0 0 Pa	art II. Other significa	ant conditions co	ontributing to death	but not res	ulting in the u	undertying	cause give	ın in Part I.	2	3e. Did toba	cco use co	ontribute to th	he cause of death
	101	PACCO	use						_	1 Pres	2 □ No	3 ☐ Prob	oabiy 4 ∐Unkr
cate has been signaled page 2 should									2	4a. Was an	241	b. Were autor	psy findings avai
oage 2									_	autopsy performe	ed? ₽No	death?	mpletion of caus 2□ No
	25. Was case referred examiner?	′ ⊢						26. Place of)		
al dire	1 ☐ Yes 2 ☑ No	0	Hospital: 1 ☐ Inpat		ER/Outpatier			4 ursir	ng Home	5 🗌 Residen	ice 6 🗆 C	Other (Specify	y)
After this funeral of	27. Manner of Death 1 ⊠Natural	5 Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time o Injury		28c. Injury Work		28d. [escribe how	injury occ	curred	
oy the	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place of Ir	Inju ry - A t ho etc. (Specif	ome, farm, str y)	M reet, facto		/es 2□No		ocation (Stre ity or Town,		mber or Rura	al Route Number,
= =	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exemi	ysician: To the bes niner: On the basis and manners	st of my kno of examina stated.	owledge, deat tion and/or in	th occurred	d at the time on, in my op	e, date and p pinion, death o	lace, and di occurred at	ue to the cau the time, dat	use(s) and e and place	manner as st e, and due to	tated. the cause(s)
41 of 0m 02	29b. Signature and tit	le of certifier				29	c. License	number		290	d. Date sign	ned (Month, I	Day, Year)
	1 apr	ansa	n ose				H	onumber	973	3	6/1	105	<i>-</i>
ī/ 30	30. Name and/addres	s of person who c	completed cause of	f death (Item	n 23a) (Type,	, Print)					200	m A	

State of Maryland / Department of Health and Mental Hygiene

			otato or mary are	Cen	tificate of	Death		leg. No.	15	198	50
		1. Decedent's Name (First, Middle, La	st)				2. Dete of Dee Month		Year	3. Time of	
	Physician /Medical	12 / 12 [1 11]		TAYLO			06	10 2	2005	12:45	• AM
	Examiner	4a Fecility Neme (If not institution, giv				4b. City, Town, or Lo					
		MARINER HEALTH O		at high day.	If Under 1 Year	FOREST H		HARI		Top (Ctate a	- Caraina
	Funeral Director		Sex 7. Age (In yrs. It		Months Deys	Hours Min.	8. Date of Birth Month, Day 8/8/1	0'18'E	Virg		r r-oreign
	pus M	Usuel Residenca of Decedent 10a. Stete 10b. County	10c. City	, Town or Loc	ation				10	d. Inside Cit	ty Limits
	Maryle febo	MD TT			st Hill					1 🗆 Yes	•
	with the Mar a or 28a-f o be notified	10e. Street end Number 109 Forest	Drive		10f. Zip Code 2 1	.0150		10g. Citizen of V	Whet Countr	y?	
,	eath mast	11. Marital Status	12. Was Decedent Ever in U,	S. 13. W	/as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Rac	a - America	n Indian,	
020	filed within 72 hours aftar death with the Maryland Hygiene. Whysiene. Wher than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at a Completed by Filmersi Director.	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		Yes, specify Cub ☐ Yes X2√2 No		Rican, etc.)	Specify	ck, White, el	hite	
215-0020	72 hq	15. Decedent's Ed (Specify only highest gra		16a. Decede	ent's Usual Occup	pation during most of work d)	ina	16b. Kind of Bu	ısiness/Indu	ıstry	
	led within 72 hquiligiene. her than "nature nt, the Medical E.	Elementery/Secondary (0-12)	College (1-4or 5+)		<i>ONOT use retire</i> emake r	d)		orrn h			
2	be filed withi tal Hygiene. d other than event, the H	17. Father's Neme (First, Middle, Last,)	пош	emaker	18. Mother's Name	e (First, Middle,	own h			
a	8 2 2 2	Frorett Spor	ncer			Virg		Farmer	-,		
ar Z	of be made	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street	and Number or Rur	el Route Numbe	r, City or Town,	State, Zip (Code)	
ž	and 2 seeth er n 27 le	Jerry Neaves- s	son	1955	Glen C	ove Rd.	, Darl	ington	, MD	2103	34
altimore, Maryland 2	ges 1 f of H if Iten or oth	20a. Method of Disposition 1 √ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	metery, crem	ition (Name of atory or other place Cemete		Date 13/05	20c. Location - Rugby ,		m, State	
alt	프론판결	21. Signature of Funeral Servica Licar	nsee		Name and Addre		Main C	L D-	14- 1	na 15	7214
מ	Depa Impo	Allrey f.	Moullela	па	rkinst.	н.,600	Main 5	с., ре	Ita,	PA I	/314
and the		23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that caused the death one cause on each line.	. Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory er	rest,		Approximate Interval Bety	ween
	Physician					0				Onset and D	Jeath
Ĩ.	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a. endy	tage	dun	lu					
			Due to (or	es a consequ	uence of):				i		
	d ansit	Sequentially list conditions	b. Due to for	as a consequ	anne off.						
o,	an an an inal-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•		,				1		
6876U	death certificata be executed e attanding physician and ad for use as the bunal-transit	that initiated events resulting in death) Last	C Due to (or	as a consequ	rence of):						
	1 0 0 2 Z		d.								
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л Э	sian: The law requiras that the death ce striftcate has been signed by the attend totor, paga 2 should be detached for us. Be Completed by Physician/	Part II. Other significant conditions of	contributing to death but not resu	Iting in the un	derlying cause giv	ven in Part I.		obacco use coi ∕es 2□ No		ably 4	
	ned be date	Samone					101	65 ZLINO	3 <u></u>	101) 102	
Vital Records,	The law requiras that tha ste has been signed by th paga 2 should be datach.	0 0 -4					24a. Was a	an autopsy	avai	re autopsy fi ilable prior to	0
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ř	Physician: The law this certificate has ral director, paga 2	Iselien	is her Tale	see	~		1□ Y	es 2 No	10	Yes 2D	Νο
<u> </u>	slan: entifica ector.				0.4	26. Place of Deet					
0	this caldire		Hospitel: 1 Inpatient 2 I	ER/Outpatient 28b. Time of	3LI DON		me 5 Resid			1	
	After fune	1 Naturel 5 Pending investigation	28a. Date of Injury (Month, Day Yeer)	Injury	28c. Injui Wo	rk? Yes 2 □ No	Zod. Describe ii	ow injury occur	00		
Division	il or Attending Physician: after death. Director: After this certific d in by the funeral director. Certification: To Be	2 Accident Investigation 3 Suicide 6 Could not b	28e. Place of Injury - At ho	me, farm, stre			28f. Location (S	treet and Numb	er or Rural	Route Num	ber,
2	tal or Attending P rs after death. al Director: After t led in by the funera	4 Homicide	building, etc. (Specify)			City or Tow	n, State)			
	Hospi 14 hour Funer taly fil	29a. Certifier (Check only 2 Medical Exar	nysiclan: To the best of my know miner: On the basis of examinati and manner stated.	vledge, death ion end/or inve	occurred at the tile estigation, in my o	me, date and place, opinion, death occurr	and due to the ored at the time, or	ause(s) and ma date and place,	inner as sta and due to	ted. the cause(s	;)
	within 2 To the comple				29c. Licens	se number		29d. Date signe	d (Month, D	ey, Yeer)	
	->-0	David 5	Dis		03.	2255		June 1	0.2	005	
	, 1	30. Name end address of person who	completed cause of deeth (Item	23e) (Type, F							
_	4	DR. DAVID DUNN,			, BEL A	IR, MD 21	.014				
3	State Registrar	11111 1 /	2005 32. Registrer's Signet	b A	net !						

			1 - For AMEND#9perFH6/3/09 RegistraMMFND#2perMD6/3	State of Models, BMW, BMW, BMW, BMW, BMW, BMW, BMW, BMW	laryland /	Depa <i>Cei</i>	artment of F	lealth and I Death	Mental Hyg	iene ()	05	198	69
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	Μ.			ER		2. Date of Dea Month 40 May 29,	Day 2005	Year	3. Time o	of Death a M
	Examir		4a. Facility Name (If not institution, give Holy Cross Hospital	street and number)		4b. City, Town, o Silver S	r Location of Death oring	h		nty of Death		
	Funeral Director		110-34-7220	7. A	ge (In yrs. last bi 68	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 11,	Year) 1936	Cou	place (State ntry) ica, W	
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County	.	10c. City, Tov							10d. Inside C	City Limits
	h with the A 23a or 28e-1	ai Director	Maryland Mor 10e. Street and Number 205 Montvale Terrac	etgomery	SIL	ver	Spring 10f. Zip Code 20	904	1	0g. Citizen o		ntry?	
920	hours after death with the Maryland turel, or Items 23a or 28e-f show at Exertiner must be notified at	by Funerai	11. Marital Status 11 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	В	ace - Amen lack, White, hify: Black	etc.	
Maryland 21215-0036	within 72 ene. than nei	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			(Give life.	dent's Usual Occup kind of work done DO NOT use retired amologist	ation during most of wor d)	rking	16b. Kind of Physi		ndustry	
/land 2	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Angelo Titer					18. Mother's Nar Fmzie I	ne (First, Middle, i Tenry				
dî.	and 2 s lealth ar m 27 is her treu		19a. Informant's Name/Relationship (Ty Lenworth Davis Downer 20a. Method of Disposition		other 20)5 Mc	ntvale Tem sition (Name of		er Spring,	MD 2090	4		
Baltimore,	permit. Pages 1 Department of F Importent: If ite eny injury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of inneral Service License		cemete	ry, crei Hea	ven Cemeter	ry 200	2 , 05 S			own, State Marylar	nd
Ba	Department of the control of the con		23a. Part1. Enter the disease, or com	Cole	ed the death. Do	50	Name and Addre aricis of Co O Universit	ty Blvd, W,	Silver Sp	ring, M	D 2090	L Approxima	te
No.	Pnysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Ovarian	line.		,	3	,			Interval Ber Onset and 1. Year	tween
68760,	eate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or a	s a consequence	of):							
O. Box 68	death certifica e attending ph id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death		Ectopic pregnancy Other (specify)	,			Date of deliv		Year
<u> </u>	es gu	by	Part II. Other significant conditions cor Aspiration Pneumonia,				nderlying cause giv	en in Part I.		oacco use co es 2√□No		he cause of o	
Vital Records,	The law ate has b page 2 sl	Completed							24a. Was a autops perform	v	. Were auto prior to co death? 1 \(\subseteq \text{Yes}	ppsy findings impletion of d	available ause of
ö	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No ☐ 5 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	ospital: 1 🖺 Inpat 28a. Date of Inj (Month, D	ient 2 ER/O	utpatien Time of Injury		er: 4 🗆 Nursing H	ath (Check only on dome 5 \sum Reside 28d. Describe ho	nce 6 🗆 O		(y)	
Division	deat deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Ir				Yes 2 □ No	28f. Location (St City or Town		nber or Rura	al Route Num	nber,
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	edicai C	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the bes ner: On the basis and manner s	of examination ar	e, death	occurred at the tire vestigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and rate and place	nanner as s , and due to	stated. the cause(s	s)
)	To th vithin To th compl	Me	29b. Signature and title of certifier	Regn		-	29c. Licens	e number D45121	2	9d. Date sign			
	Sta	ate.	31. Date filed (Month, Day, Year)	L500 Forest	Glen Roa	d, S	ilver Sprir	ng, MD 2090	1				
	Registi		MAY 3 1 200	5 Some	trar's Signature	Sept 18	de)						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** TRAUBEN 1038 AM 2005 ELLEN MA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore City JOHNS HOPKINS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Dete of Birth (Month, Day, Yeer) **Funeral** Months Days Hours 1 □ M 2 X F 40 Yrs 19, 1965 Director Minnesota 468-58-9134 Feb. Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and & succession of the substance of the 1 ☑ Yes 2 ☐ No Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20015 United States 3819 Morrison Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker Social Work 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Sally Leafman Kenneth Appelbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3819 Morrison St., NW, Washington, DC Steven Trauben, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Lebanon Cemetery | 05/26/05 Adelphi, MD 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Funeral 254 Carroll St., NW, Washington, DC

23a. Part 1 Enterne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LYMPHOMA **Physician** Tears /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 PNo 3 Probably 4 Unknown 1 TYes preumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2□ No 1 Tyes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a. To the Funerat C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier May PES-000 MIT 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 600 North Wolfe Street Robin Veidt Maryland 31. Date filed (Month, Day, Year) State 31 2005 Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 63. A = D A = E 44 A T D A B (WA A V) Turk H. 11:	2 NAV
te 31. Date filed (Month, Day, Year) 2. Registrar's Signature	1010
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		For State Registrar	State of N	Marylan		artment o			ental Hyg	iene eg. No.) 05	198	72
Physicia	n	1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month	th Day	Year	3. Time of (Death
/Medica	at .	David Erskine W							5	29	2005	4:50	P ^M
Examine	er	4a. Facility Name (If not institution, give st				4b. City, Tow	m, or Location	on of Death			ounty of Death		
Europol		Atlantic Genera 5. Social Security Number 6. Sex	7.7		last birthday)	If Under 1 Y		der 24 Hrs.	8. Date of Birth		Vorcesto	er ace (State or try)	r Foreian
Funeral Director		204-30-6436	M 201E	80	Yrs.	Months Da	ays Hour	rs Min.	8. Date of Birth (Month, Day, 7/16/1	924		nbersb	
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	9	David E. Witherspo							lanche :				
re, Maryle re, Maryle s 1 and 2 should Health and Mer tiem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Bonnie Miller	e, Print)		1	ng Address (Str			anda. P			Code)	
	- 1	20a. Method of Disposition			lace of Dispo	osition (Name o matory or other	f				ion - City or To	wn, State	
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Baltime Baltime Baltime permit. Page Department Important: If any injury or once.	ï	21. Signature of Funeral Service Licensee	· R			2. Name and A		and the same of th	e Burb				
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3.		28a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	ations that caus cause on each	ed be death i line.	Do not en	ter the mode of	dying, such	as cardiac or	r respiratory arre	est,		Approximate Interval Betw Onset and De	veen
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ords	ed	Diabeles							1 □ Ye	is 2□N	io 3 🗆 Proba	ıbiy 4 X]Ur	ıknown
Record law requir	Completed								24a. Was ar	n 2	4b. Were autop	sy findings av	variable
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Division of Vital Records, P.O. Box 68760, or attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.	lica Lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of I	Injury - At ho	me, farm, st	reet, factory, off			8f. Location (Str		umber or Rural	Route Numbe	ΘΓ,
Div	Certification;	4 Homicide determined	bullding,	етс. (<i>Specin</i> y	/)				City or Town	, State)			
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o the omple	Med	29b. Signature and title of certifier	and manner	maidu.		29c. Lic	ense numbe	er	29	d. Date si	gned (Month, E	Pay, Year)	
- se o		1 July 1				C.	347	168		6	11/05	-	
		30. Name and a dress of person who	pleted cause of	f death (Item	23a) (Type.			- 0			1-1-03		
C. H. 6		Jeffrey M. Wieland	M.D.		0 East	tern Av	e., S	alisbu	ry, Md.	2180)2		
State Registra	e	31. Date filed (Month, Day, Year) 2 20	05 32. Pois	strar's Signa	ture	had s			200				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician 2005 10:20 P.M. Conchita Venice Wynn May /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Home, Inc. Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/1/33 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 6. Sex **Funeral** Months Days Hours 1□M 2፟MF 72 Annapolis, Md. Director 579-42-5220 Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State ral', or items 23a or 28a-f sho Examiner must be notified at Yes 2□ No Md. Silver Spring Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 9039 Sligo Creek Parkway # 1108 20901 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Black "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Health Care h end Mentel Hygie 2 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Lest) Unknown Theresa Brown 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health e important: if item 27 is any injury or other training. John H. Francis/Cousin 4900 Keir Court, Suitland, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 6/2/05 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licensee 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Month) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death cartificate be axecuted attanding physician and for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 1 No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours effar death. To the Funeral Director: After this certificate has been si completaly filled in by the funaral director, page 2 should Completed 1 Yes 3 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To 1 ☐ Yes 2 ☐ No 27. Menner of Death 1 Naturel 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 TNo 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier within 2 To the 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature end title of certifier 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 3 62 ndves

DHMH 16 Rev 6/95

State Registrar 31. Date filed

2. Registrar's Signature

			Please Type or Print in Black In State of Maryland / Dep.		•	•
			1- State Registrer Ce	rtificate of Death	Re	No. 198/4
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Zelda Elizabeth Wood		2. Date of Death Month May 27	Day 2005 1008 p M
	Examin	er	4a. Facility Name (If not institution, give street and number) Doctors Hospital	4b. City, Town, or Location of Lanham		4c. County of Death Prince George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 577–46–8137 1 M 2 TF 70 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day, 1)	9. Birthplace (State or Foreign Country) Wash., DC
	Maryland a-1 show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George s	Hyattsvill	e	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	i Direc	10e. Street and Number 5805 - 42nd Ave., #217	10f. Zip Code 207		g. Citizen of What Country? United States
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural; or Itams 23e or 28e-f show any injury or other traumatic avant, Ital Madical Exact as Innatice Indiffed at Once.	by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forcas?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I		14. Race - American Indian, Black, White, etc. Specify: Black
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yları	Suld be Mental arkad c	To B	Arthur Green		Ethel Da	andridge
Z Z	nd 2 shi Ith and 27 is m r traum			ng Address (Street and Number) 578 Primrose, Rd		
i ore	ages 1 ar ant of Hea nt: If item y or otha		20a. Method of Disposition 20b. Place of Disposition 1 Natural 2 Cremation 3 Removal from State		Date 20	Cheltenham, MD
Dalillino	permit. F Departme Importan any injur			2. Name and Address of Facility	Stewart F	ineral Home
	70 F 4 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			ash., DC 20019
ı	Physician		Immediate Cause (Final disease or condition CARNIAC A	PRHYTHMI		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	ORY FA	LORE.	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	GPD.		
,007	ate be executed hysician and ihe burial-transit	cai	resulting in death) Last Due to (or as a consequence of): d.			
O. BOX 00	o the Hospital or Attending Phyelician: The law requires that the death certificate be executed within 24 brours after death. On the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ď,	uires that to signed by Id be detac	by	Part II. Dther significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I.		cco use contribute to the cause of death?
records,	The law rec te has beer age 2 shou	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
110	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?		f Death (Check only one)	
5	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	tion; To	1 Yes 2 Ro Hospital: Impatient 2 ER/Outpatien 27. Manner of Death 28a. Late of Injury (Month, Day Year) Accident investigation		ing Home 5 Residen 28d. Describe how	
	al or Atten s after deat I Diractor: d in by the	Certification;	9			et and Number or Rural Route Number, State)
	ne Hospitt 24 hours ne Funara Netely fille	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deat seminer: On the basis of examination and/or in and manner stated.			
	To the within	Ň	29b. Signature and title of certifier	29c. License number	25 0	d. Date signed (Month, Day, Year)
,	MM		30. Name and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cause of death (Item 23a) (Type, Some and Address of person who completed cau	Print) the last of	l Road;	€220, BOWIE NO (6
	Sta Reg ístr		31. Date filed (Month, Day, Year) 32, Registrar's Signature	,		

DHMH 17 Rev 1/2001

Zelda Elizabeth Wood

			1 = State Registrar	State of Marylar	•	artment of H		ind Me	ntal Hy	giene Reg. No	Z U U 3	19875
			Decedent's Name (First, Middle, Last)					2	2. Date of De			3. Time of Death
	Physicia /Medic		Robert Wa	ayne Watsor	ì				Month June	2,	2005	11:45A M
)	Examin		4e. Facility Name (If not institution, give st			4b. City, Town, o	r Location of	f Death		4c	. County of De	
			Corsica Hills N			Centr				_	_	Anne's
	Funeral		5. Social Security Number 6. Sex	M 2 ☐ F 7. Age (In yrs.	Vec	If Under 1 Year Months Days	Hours 1	Min.	Month, De	y, Year)		inthplece (Stete or Foreign Country)
	Director		219-64-8038 Usuel Residence of Decedent		51 113.				June 1	4, 1	953 Ma	aryland
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Mary First	to	Maryland Caroline	, De	nton							1 ☐ Yes 2 ☐ No
	r 28s	Director	Maryland Caroline 10e. Street and Number		110011	10f. Zip Code				10g. Cit	tizen of What C	Country?
	death with the Maryland ms 23a or 28a-f show		600 Caroline Apt.	608		21629				Unit	ed Stat	tes of Americ
	ams	Funeral		Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Orig an, Mexican,	in? (Speci Puerto Ri	fy Yes or No can, etc.))-	14. Race - Arr Black, Wh	
9	or It	by Fu	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:				Specify:	
9500-6121	hour: tural'		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occup	ation			16h K	ind of Busines	aucasian s/Industry
Ċ	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done	during most	of working	7	TOD. IX	and or busines	arridustry
7	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Certi	fied Nur	se's A	Aide			Medica	al
פַ	be filed within 72 hours after death with the Marylan lat Hygiene. d other then "natural", or Itams 23a or 28a-1 show event, I're Medical Examiliar must be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (First, Middle	, Maiden	Sumame)	
land		ToE	Arthur Rov	Watson			Ic	da Mae	e Hanc	ock		
Mary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ			ng Address (Street						
	Health Health tem 27		Andrew R. Watson	Brother	_	Court Stre	eet, A			_		
ore	Pages 1 nent of H int: If Itel		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	cemetery, crei	nsition (Name of matory or other place		Da 5/3/20			ocation - City o	
	. Pag tment tant: jury		* 4 ☐ Donation 5 ☐ Other (Specify)		-	Cremator	4			DOVE	er, Dela	aware
Baitimore,	permit. Pages Department of I Important: If Ite eny injury or o'		21. Signature of Funeral Service License	h	N N	Name and Addre Noore Fund	ss of Facility eral F	iome,	P.A.			
	40300		23a, Part1, Enler the disease or complic	various that caused the dea							n, Mar	yland 21629
			shock, or heart failure. List only one	e cause on each line.	11 1	1	ig, such as t	Dardiac Or	iospiiatory a	11031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		H 1	V						
	Examiner			Due to (or as a conse	quence of):							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):							
	uted d ansit	Examin	cause. Enter Underlying Cause Disease of injury that initiated events									
Ď,	exec an an rial-tr		resulting in death) Last	Due to (or as a consec	quence of):							
09/8	death certificate be executed e attending physician and of for use as the burial-transit	dlcal	d.									
0	rtifica ng ph s as tl	Med	IF FEMALE:									
XOA	leath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	aldeath 3	Ectopic pregnancy	/				23d. Date of de Month	elivery Day Year
0	at the dea by the an	/s c	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)						,
J.	law requires that the as been signed by th 2 should be detache	Ph)	Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		23e, Did	tobacco	use contribute	to the cause of death?
Vital Records,	ires that signed b	1 by	Colon cons		.				1			Probably 4 Unknown
Ö	w requir been si should	Completed	000000						24a. Was		Odb Warn	autoportinding orgalishte
ě	0 - 2	I du							auto		prior to	autopsy findings available completion of cause of
ā	T ate	e Co	75 Mee ease referred to medical				00 Bl	-4 D 15 /	1 ☐ Yes	2 X No	1 ☐ Ye	s 2 No
=		o Be	25. Was case referred to medical examiner? 1 Yes 2 40	ospital:] ER/Outpatier	nt 3 DOA Oth	ar.		Check only		6 □Other (Sp	acity)
Ö	Phys er this eral di	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time o				d. Describe			o City)
0	nding F th.:: Alter a funer	atloi	1 Statural 5 ☐ Pending investigation	(Month, Day Yeer)	Injury		k? Yes 2 ⊡ N	No				
Division of	of or Attendination of a standination of the standing of the s	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, st	reet, factory, office		28	f. Location (Street ar	nd Number or F	Rural Route Number,
	tal or is afte al Dir	Cert	Tomodo	building, old. (opso-							·/	
	t hour			icien: To the best of my kn er: On the basis of examin								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the fune	Medical	one)	and manner stated.								
	With To		29b. Signature and title of pertifler	11.		29c. Licens	3 7 "	> 1		zau. Da	te signed (Mor	
			1) 1/10	W /		(3	100	4 9			2 (3/2	447
			30. Name and address of perion who cor	mpleted cause of death (Ite	m 23a) (Type,	Print)	uho 1	0.00		2	Le Mi	11/10
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	121 1200	V	100		131	Ley J. W.	all ly
ř	Regist		JUN - 3	2005	K	Bosel &						

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05-	00260		For State Registrar	Sta	te of Ma	aryland /		artment of H tificate of L		nd Men		iene? (105	19876
	Physici		1. Decedent's Name (First, Mida	le, Last)							ate of Deat		Year	3. Time of Death
	/Medic		Anto				Art				nuary		2005	20:05 M
1	Examin	er	4a. Facility Name (If not institution 541 West 27th		nd number)			4b. City, Town, or Balti		f Death		1	ty of Death N/A	
	Funeral Director		5. Social Security Number 214-98-7894	6. Sex		e (In yrs. last b 38	irthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (/	Date of Birth Month, Day,	Year) , 1966	Cou	place (State or Foreign ntry) nknown
	and w		Usual Residence of Decedent 10a. State 10b. County	,		10c. City, Tov	wn or Lo	cation				-		10d. Inside City Limits
	Mary e-f she	tor	Maryland			Ва	alti:	more						1 DXYes 2 □ No
	ith the	Director	10e. Street and Number					10f. Zip Code			1	0g. Citizen of	What Cou	intry?
	s 23a		541 W. 27th St				1.0.1	21211				nited		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show eny injury or other traumatic event, I'm Madical Exerciner russ be notified at 2008.	by Funerai	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 [s Decedent ned Forces?]Yes 2v ! 'es, Give ar or Dates:			Was Decedent of Hi fYes, specify Cuba I□Yes 2☐√No	spanic Orig n, Mexican, Specify:	nn? (Specify , Puerto Ricai	n, etc.)		ack, White	ican Indian, , etc. Black
9	2 hou	ted	15. Decede	nt's Education		168	a. Deced	lent's Usual Occupa	ation			16b. Kind of I		
Maryland 21215-0036	vithin 7. ne. han "n	Completed	(Specify only higher Elementary/Secondary (0-12)	Co	llege (1-4or 5	i+)	life. I	kind of work done o DO NOT use retired	luring most)	of working				
d 2	filed w Hygie ther t		unknown 17. Father's Name (First, Middle		nown		La	borer	18. Mother	r's Name (Fin	st, Middle, M	Paint Maiden Suma		
lan	fental fental rked o	To Be		nown					Sa	rah				Woods
lary	and No	-	19a. Informant's Name/Relation	ship (Type, Pri	nt)	19	b. Mailir	g Address (Street a	and Numbe	r or Rural Ro	ute Number	City or Town	n, State, Zi	p Code)
. ≥ √	and 2 lealth m 27 i		Mr. Manley Cos	sper (f	riend)			W. 24th S	treet					
Baltimore,	Pages 1 nent of H ent: if ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (il from State	cemet	өгу, стөг	sition <i>(Name of</i> natory or other plac Cemetery		Date . 21,		20c. Location Balt	•	own, State
Balt	permit. Departitimport		21. Signature of Funery Service	Licensee	7 B	rian T.	Ch:	Name and Address isholm Fu JU E. Pad	s of Facility neral	Servi	ces o	f Dula	ney V	alley, P.A.
	Physician /Medical		21 nt1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_ a	Gun	shot i	NO C		g, such as o				D 21	Approximate Interval Between Onset and Death
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	pe isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	▗┈	Due to (or as	a consequence	e of):							
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687	ficate be ex physician s the buria	edicai		d										
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ds, P	uires that i signed b ld be deta		Part II. Other significant condit	ions contribution	ng to death b	ut not resulting	in the u	nderlying cause give	en in Part I.		23e. Did tot 1 ☐ Ye	-1		the cause of death?
ecor	law requir as been si 2 should l	Completed									24a. Was a autops		. Were aut	opsy findings available ompletion of cause of
I Re	The lay	Com									perform	ned? 2 □ No	death?	
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	al Hospita	l·			Othe		of Death (Ch				
of	Phys r this ral dir	. To	1 X Yes 2 No 27. Manner of Death		. Date of Inju (Month, Da	ent 2 ER/C	outpatier . Time of	3 DOA	4 1401			once 6XO		fy) SCENE
ion	nding Ph ath. r: After th e funeral	atior	1 ☐ Natural 5 ☐ Pend 2 ☐ Accident inves	9	(Month, Da		Injury	D M 1 D	<br Yes 2∭∆1	No Su	bjert	was	sho	+
Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could deter	not be mined 28e	. Place of In building, et	c. (Specify)		eet, factory, office		1 0	Location (St City or Town	, State) 5	TI WE	al Route Number, of 27th Street
	To the Hospitel within 24 hours a To the Funerei Completely filled	Medical (29a. Certifier 1 Certify (Check only one) 1 Medica	I Examiner: O	To the best n the basis o nd manner st	of my knowledg	teah an	n occurred at the time vestigation, in my of	ne, date and pinion, deat	d place, and o	tue to the co	use/s) and n	nanner ac	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifi	er M.	<u>ک</u>			29c. License	·M.E.	<u> </u>		9d. Date sign January		
			30. Name and address of perso	who complete						altima:				
	Sta	te	31. Date filed (Month, Day, Yea	mis	32. Pegistr				CL, D	CIT CITIO	re, M	агу тап	1 ZTZ	OT
	Regist		JUN 1		Bree	ar's Signature	A	od)						

Dorothy Rose11e Graham Alexander June 10, 2005 As Facility Name (for residuation, give staves and number) As Day, Town, closation of Death Accounty Accou	
Drochy Roselle Graham Alexander June 10, 2005 As Facility Name (if not institution, give strease and number) As Facility Name (if not institution, give strease and number) As Facility Name (if not institution, give strease and number) As Facility Name (if not institution, give strease and number) As Facility Name (if not institution, give strease and number) As Facility Name (if not institution, give strease and number) Social Security Number (i. Sec. Sec. V) Montgomery Hospice Casey House Social Security Number (i. Sec. Sec. V) As June 10, 2005 As Facility Name (if not institution, give strease and number) Social Security Number (i. Sec. Sec. V) As June 10, 2005 Social Security Number (i. Sec. Sec. V) Montgomery Hospice Casey House Social Security Number (i. Sec. Sec. V) As June 10, 2005 Social Security Number (i. Sec. Sec. V) As June 10, 2005 Social Security Number (i. Sec. Sec. V) As June 10, 2005 Social Security Number (i. Sec. Sec. V) As June 10, 2005 Social Security Number (i. Sec. Sec. V) As June 10, 2005 Social Security Number (ii. Sec. Sec. V) As June 10, 2005 Social Security Number (ii. Sec. Sec. V) As June 10, 2005 Social Security Number (ii. Sec. Sec. V) As June 10, 2005 Social Security Number (ii. Sec. Sec. V) As June 10, 2005 Social Security Number (ii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. V) As June 10, 2005 Social Security Number (iii. Sec. V) As June 10, 2005 Social Security Number (iii. S	3. Time of Death
## Facility Name (If not institution, give street and number) ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey House ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Hospice Casey ## Montgomery Hospice Hospice Casey ## Montgomery Hospice Casey ## Montgomery Hospice Hospice Casey ## Montgomery Hospice Hospice Casey ## Montgomery Hospice Hospice Casey ## Montgomery Hospice Hospice Casey ## Montgomery Hospice Hospice Casey ## Montgomery Hospice Hospi	4:50 PM M
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282-18-6014 10 20 28 29 20 20 20 20 20 20 20	ntgomery
Description Description	Birthplace (State or Foreign Country)
Second Company Compa	Ohio
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	10d. Inside City Limits
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20. Location Company or other place) 20. Location Company or other place) 20. Location Company or other place) 20. Location Company or other place) 20. Location Company or other place) 20. Location Company or other place) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Rockville, Inc. 300 West Montgomer Rockvill	te, Zip Code)
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Physician Medical Examiner Physician Medical Examiner 23a. Part I. Enter the disease, or-empfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that infinited events resulting in death) Due to (or as a consequence of): Due to (
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1 Yes 2 No 1	e autopsy findings available
25. Was case referred to medical examiner? 1 Ves 2X No Check only one Check only	r to completion of cause of th? Yes 2 □ No
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the state of the cause (s) and mann stated. 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	er as stated.
29a. Certifier 29a. C	due to the cause(s)
and manner stated. 29b. Signature and title of certifier 29d. Date signed (a	fonth, Day, Year)
041218 6/1	1/05
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
O 1 1 M H W D (001 W D - 1 D - 1 D - 1 D - 1 D - 1 D - 1	
Charles M. Harrison, M.D. 6001 Muncaster Mill Road Rockville, Maryland State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 5 2005	20855

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, Examiner or Location of Death mure If Under 1 Year | If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 □ M 2 X F Min. Director 217-24-2749 Yrs 76 11-1-28 Md. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Exemple must be notified at Director 1 X Yes 2 ☐ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 N. Charles Street Apt. 1517 21201 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give⁴ Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1

Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3 No þ Specify: 3 Widowed 4 Divorced Black naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Clerk Social Security Admin. 12th grade 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Lighner Laura Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 is any injury or other treu QDC6. Michael R. Catchember Cousin 1017 Upnor Rd., Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
' 4 □ Donation 5 □ Other (Specify) Arbutus Mem. Park 6 - 15 - 05Arbutus, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Unidenying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical JE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 4 Inknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 10 lo autopsy perform 2 000 Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 10 atient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Patural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funerel C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Description Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b Signature and title of certified 0 (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) Date of Deeth
 Month **Physician** 5:30 AM William Gill Brooks 2005 June /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** 2413 Still Forest Rd. Baltimore Pikesville If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 215-22-3973 1XM 2□ F Yrs. Director Sept. 23,1927 Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-1 show any injury or other traumetic event, the Madical Exercises. 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Pikesville Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2413 Still Forest Rd. United States 21208 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:1946-55 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) banker/financial consultant banking/schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Rodney Joseph Brooks Mary Agnes Rodgers 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2413 Still Forest Rd. Pikesville, MD 21208 Jean W. Brooks/wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/05 Baltimore, Maryland Greenmount crematory 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
Raltimore, MD 21212 21. Signature of Funeral Service Licenses 6500 York Rd. 23 P/n1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Physician tery disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner attending physician end for use es the bunel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 710 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Medical Certification: To 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury et Work? 27. Menner eth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Meturel 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Extifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner stated. (Check only one) 29b. Signature end title of certifier, 29c. License number 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) 21 West Rel Jouveinemo 31. Dete filed (Month, Day, Yeer) State JUN 1 5 2005 Registrar

Linds Blackwell Bright Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03864 Unpend Item 23a&27 per me G844 6-16-05 tas

Certificate of Death

Reg. No. RJ 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death June 6, **Physician** LINDA 2005 5:04 a. M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Cduntay) **Funeral** 1 M 2 F Director the Maryland 10a. State 10b. County 10c. City, Nown or Location 28a-f show other traumatic event, the Madical Examiner must be notified at AUTIMORE 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces

1 ☐ Yes 2 ☐ No 72 hours after 1 Never Married ☐Yes 2 Yes. Give 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Š Specify. 3 Widowed 4 Divorced Year or Dates: "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then 7 any injury or other traumatic event ortery (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sur OSHA MAE † Father's Name (First, Middle, Last) Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility um 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Complications of Idiopathic Thrombocytopenia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 \sum No 24a. Was an autopsy performed? 2 🗆 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: X Yes 2 □ No 2 4 ☐ Nursing Home 5 ☐ Residence 💥 Other (Specify) Scene filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Tyes 2 No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME June 6, 2005

State Registrar ramela

31. Date filed (Month, Day, Year)

mi

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type. Print) 111 Penn Street Baltimore, Maryland 21201

	•	For State Registrar	State of Maryland / Dep.	rtificate of Death		Reg. No.2	5 1000
Physicia	ın	1. Decedent's Name (First, Middle, Last DENISE			2. Date of De Month June	400 10 13	3. Time of Deat 20:25
/Medica Examine	_	4a. Facility Name (If not institution, give Sinai Hospital	street and number)	4b. City, Town, or Location of Death Baltimore		4c. County of D	
Funeral Director	e	5. Social Security Number 6. Se 214-65-2617 Usuel Residence of Decedent	7. Age (In yrs. last birthday) M 2XF 50 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	th ay, Year) ER 3,1954 M	Birthplace (State or For Country) DARYLANI
ith the Maryland or 28a-f show a notified at	Director	10a. State 10b. County MARYLAND N/A	10c. City, Town or Lo BALTI				10d. Inside City Lin
23a or 24		10e. Street and Number 3821 ROLA	UD VIEW AVENUE	10f. Zip Code 2/2/5		10g. Citizen of What	Country?
urs a	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 KINo	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No Rican, etc.)	11.00	merican Indian, hite, etc.
be filed within 72 ho ital Hygiene. Ind other than "natura event, the Marical E	Completed	15. Decedent's Edu (Specify only highest grad	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		16b. Kind of Busine	
ed fall	a l	17. Father's Name (First, Middle, Last) HOWARD	WILLIAM	18. Mother's Nam	e (First, Middle,	BALTO, CTY Maiden Sumame) BOY	
± 2 € g		19a. Informant's Name/Relationship (T)		ig Address (Street and Number or Rui	al Route Numbe	er. City or Town. State	. Zip Code)
Pages 1 ar nent of Hea ant: If item: ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place) CREMATORY JUNE	Date	20c. Location - City	or Town, State
permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Licens	". William 30	Name and Address of Facility SEPH H. BROWN	JR. FUL	IERAL HOME	2140 N. FULT
nysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Chronic Pericarditis Wi				Approximate Interval Between Onset and Deat
Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
physician and the burial-transit	Ехаш	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hypertensive Atherosc1 Due to (or as a consequence of):	erctic Cardiovascular	Disease		
	Me Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
w requires that been signed I should be det	2		ntributing to death but not resulting in the understanding to death but not resulting in the understanding to the understanding the understanding to the understanding to death but not resulting in the understanding to death but not resulting in the understanding to death but not resulting in the understanding to death but not resulting in the understanding to death but not resulting in the understanding to death but not resulting in the understanding to death but not resultin		23e. Did to	obacco use contribute es 2 No 3 🗆	to the cause of death
certificate has been s rector, page 2 should					24a. Was a autop: perfor	an 24b. Were sy prior to death? 2 \(\text{No} \) No	autopsy findings availa completion of cause as 2 No
iding Physician: After this certific funeral director,	2	25. Was case referred to medical examiner? X	ospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		me 5 Resid	ence 6 Other (Sp.	ecify)
ra for Attanding Processing the safet death. all Diractor: After the formers of the funers. Certification.	oei ei ca	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Si City or Town	itreet and Number or I n, State)	Rural Route Number,
ne nospa n 24 hou ha Funar pletely fill	ealcal	one)	ician: To the best of my knowledge, death ler: On the basis of examination and/or inv and marifler stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)
Som Som	Ξ :	29b. Signature and title of certifier		29c. License number OCME	2	June 08,	
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			1 - For State Registrar	State of M	laryland / De _l	oartment e <i>rtificate</i>			and M		giene	005	19882
			Decedent's Name (First, Middle, I	.ast)						2. Date of Dea	th		3. Time of Death
	Physici /Medi		Jesse L.	Brown						Month 06	04	05	9:35 A M
	Examir		4a. Facility Name (If not institution, g	ive street and number)	4b. City,	Town, or	Location o	of Death		4c. Co	ounty of Death	
ij.			Heartland of Hy					ville			Pı	ince G	eorges
	Funeral			Sex 7. A 1 □ X M 2 □ F	ge (In yrs. last birthda	y) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
	Director		577-28-8313 Usual Residence of Decedent	T IVITED TO	81 Yrs.					11 26			. D.C.
	land ow		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Many Fed	ţō	MD Prince	Georges	Mt. Ra:	inier							1⊠Yes 2□No
	r 28a	Director	10e. Street and Number			10f. Zip	Code				l0g. Citize	n of What Cou	ntry?
	h wit		3307 Otis Street			20.	712				•	USA	
	dea ems	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Americ	
9	or It	F.	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 ☐	No	1 ☐ Yes 2		Specify:	, Риепо і	rican, etc.)		Black, White,	
8	ural',	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:		10,163 2		эрвыу.			5,	pecify: Blac	: k
5	within 72 hours after death with the Maryland ene. than "natural; or Items 23a or 28a-f show ha Mudical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Gin	edent's Usual re kind of won	k done d	urina most	of workir	ng	16b. Kind	of Business/In	dustry
12	withis ene. than	ద	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT usi ceman	e retirea,				D C	Gover	nment
9	be filed within 72 hours after death with the Marylan ntal Hygiene. dd other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be notified at		17. Father's Name (First, Middle, Las	st)	1 1 1	eman		18. Mother	r's Name	(First, Middle,			interio
lan	2 should be and Mental is marked or raumatic eve	To Be	Jesse Brown							rimas		,	
ary	shou and N s mai	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address	(Street a	nd Numbei	r or Rura	Route Number	, City or T	own, State, Zip	Code)
Σ	of Health ar item 27 is other trau		Michael Brown/S	on	P.O.	Box 4	52 I	MtRai	nier	, MD. 2	0712		
ore	of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Dis		e of					tion - City or To	own, State
Ĕ	Pag ment ant: I ury o		'4 □ Donation 5 □ Other (Spec		Quantico			*	6 - 13	- 05	Trian	gle, VA	. A.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.		21. Signature of Funeral Service Lice	ensee		22. Name and	Addres	s of Facility	MAr	shall's	Fune	ral Hor	ne
	70 = 4 O		* 8 ma	shall		217 9t	h. 9	St. N	.W. 1	Washing	ton,	D.C. 20	0011
			23a. Parti. Enter the disease, or conshock, or heart failure. List only	y one cause on each	ine.			, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardio	respirator	y Arre	st						Onset and Death
	Examiner		Tooding in dodon,	Due to (or as	a consequence of):				-				
		er	Sequentially list conditions, if any, leading to immediate	b. Alzein Due to (or as	ers Dement	ia							
	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate eause. Lister Underlying Cause (Disease or injury that initiated events										
o	an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):							-	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	dical		d									
9 ×	death certifica attending pt 3 for use as t	a	IF FEMALE:	"									
Вох	attenc for us	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pre					23d	. Date of delive Month	ry Day Year
o.	that the de led by the a detached t	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 5	Other (spe	cify)						Day Tour
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Y		1	Dr. Soreshkum	ar Muttath				ry Ro	ad,	Hyattsv	ille,	MD. 20	0781
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [19883 1 - For Stete Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 08 BROWN Month Year WALLACE EUGENE 07:30 PM 2005 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE CITY N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Dave Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 **X**M 2 □ F Yrs Director 217-34-9626 66 Dec 31, 1938 Maryland Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Modical Examinar must be notified at Director 1 Yes 2 □ No Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 710 Deacon Hill Court 21225 U.S.A. or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo þ Specify: Specify Black 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) **Erachem Conilog Chemical** Chemical Plant Operator Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 is marked other t 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis H. Brown Bessie R. Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itam 27 is any injury or other tratence. 710 Deacon Hill Court Baltimore, Md. 21225 Minnie Brown Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2 □ Cremation 3 □ Removal from State 06/14/05 Pasadena, Marviand 4 □ Donation 5 □ Other (Specify) Mt. Zion U. M. Church Cemetery 21. Signature of Funeral Service Lio 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician POST OBSTRUCTIVE PNEUMONIA 15DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 MONTHS CARCINOMA -UNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Completed by Physician/Medical Exam Box 68760, A Due to (or as a consequence of): physician s the burial IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, HYPERTENSION HYPERCHOLESTERLEMIA 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No page 2 s autopsy performed? 1 ☐ Yes 2 No To the Hospital or Attanding Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To tha Funaral D 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 ☐ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one)

3001 31. Date filed (Month, Day, Year) JUN 1 5 2005 State Registrar

29b. Signature and title of certifier

/aundu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

OOO RESI

29d. Date signed (Month, Dav. Year)

8 2005

JUNE

BALTIMORE MARYLAND 21225

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JUNE 7, **Physician** 2005 10:20 AM WARREN CALVIN BARKLEY /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WASHINGTON HAGERSTOWN BROADMORE ASSISTED LIVING 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/10/1921 5. Social Security Number **Funeral** Days Hours PENNSY LVANIA 1 X X 2 □ F 175-14-0988 84 Yrs Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 No MARTINSBURG Director BERKELEY WV 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25401 USA 712 W. JOHN STREET filed within 72 hours after death Hygiene. nther than "natural", or Items 23 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FAIRCHILD INDUSTRIES Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR (AIRPLANE MANUFACTURING) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mental F BALSENY LAURA CHARLES C. BARKLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 712 W. JOHN STREET, MARTINSBURG, WV 25401 Department of Health Important: If item 27 I JULIA BARKLEY/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State JUNE $^{ ext{Date}}_{11}$. Pages 1 5 ROSEDALE CEMÉTERY 4 Donation 5 Other (Specify) 2005 MARTINSBURG, WV ²BRÖWN FÜNERÄL HÖME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 21. Signature of Funeral Service Licensee 'n sion 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Tue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit attending physician and Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use commoute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 25 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier Tune 9,2005 address of person who completed cause of death (Item 23a) (Type, Print) HAGGERSTONN, MD 21740 424 OPAL CT. COPPECES, ON.O TERRY 31. Date filed (Month, Day, Year) JUN 15 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 2 per doc 8844 6-21-05 vt

Amend item 2 per doc 8844 6-21-05 vt

Debartment of Health and Mental Hygiene

Physician (Medical Examiner 4. Facility Name (If not institution, give street and number) 4. Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 1. A Facility Name (If not institution, give street and number) 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 2. Social Security Number 3. Social Security Number 3. Social Security Number 3. Social Security Number 4. Social Security Number 4. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Number 1. Social Security Nu		1 - For State Registrer		epartment of Health and Certificate of Death	Reg	No. 2005	1 10 10
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/14/05 30. Name and address of person who compled cause of death (Item 23a) (Type, Print)	Hospita 24 hours Funeral letely filled	29a. Certifier (Check only one) Certifying Phy	iner: On the basis of examination and and manner stated.	or investigation, in my opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show eny injury or other traumatic event, It a Modical Examiner must be notified at once.	Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0·12) 12	ducation ide completed) College (1-4o		16a. Deced (Give i life. D	ent's Usual kind of work OO NOT use	done du retired)	ion ring most of mer	working	1	6b. Kind of Bu	Farm		
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Y	The ate h	Completed		Pulp	cra	£_	whe	Diso	ソ	-	24a. Was an autopsy performe I 🗌 Yes 2	24b. W	/ere auto rior to cor eath? Yes	psy findings ava npletion of caus 2 No	ailable se of
DIVISION OF VITAL	ling Phy h. After this funeral d	ertification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpati 28a. Date of Inji (Month, Da	ıry 28	/Outpatient b. Time of Injury		Other: c. Injury at Work?	4 Nursing	g Home		ce 6 ⊡Othe)	
Ž O	r te	OF	3 Suicide 6 Could not be determined	building, e	tc. (Specify)					(City or Town,	State)		l Route Number	r.
	To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1	ysician: To the best iner: On the basis of and manner st	i examination	dge, death and/or inve	stigation, ir	the time, n my opin icense n	ion, death oc	ace, and o	the time, date	se(s) and mar e and place, a d. Date signed	nd due to	the cause(s)	
	D-3-8		30. Name and address of person who o	ompleted cause of	7 How	Sing.						me, mp	10	2005	5
	Sta	te	B. TURAKHIA 31. Date filed (Month, Pay, Year) 301	, MD io	ar's Signature	Seele	wick.	Ro	. Co-	fers	ville	, MD	212	28	
	Registra	* 4	JUN 1 5 20	Block	15	Apple									

			1 - For State Registrar AMEND TIEM	State of Maryland / Do				giene	pro 1 con many
	Physic		1. Decedent's Name (First, Middle, Last)	aker	6 8/12/05	JIP	2. Date of Dea Month June	ith _	3. Time of Death 5:35 P M
	/Medi Examir		4a. Facility Name (If not institution, give st		4b. City, Town,	or Location of Death	ounc	4c. County of E	
	LAGIIII		1719 Laurel Brook	Rd.	Fallst			Harfor	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		15/-18-9010	M 21XF 81 Y	s. World's Days	710013	Aug. 8,		Vew Jersey
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	ne Maryi 8e-1 sho	ctor	Md. Harford (VILLE			1 □ Yes 2√ No
	72 hours after death with the Maryland naturel', or items 23e or 28e-1 show disal Examiner must be notified at	Funeral Director	10e. Street and Number 4403 RA	YMOND AVENUE -Rd.	10f. Zip Code 2104	7 21784	i i	10g. Citizen of Wha	t Country? USA
	tems terms	rue	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
21215-0036	ours afterell, or i	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No		,	Specify:	White
5-0	72 h "natu dical	etec	15. Decedent's Educ (Specify only highest grade	ation 16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of work	ing	16b. Kind of Busine	ess/Industry
121	within iene.	Completed	Elementary/Secondary (0-12)		fe. DO NOT use retire upational			Occupati	onal Therapy
	illed Hygie other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	· · · · · · · · · · · · · · · · · · ·	13
Maryland	should be and Mental s marked o	ToB	David W. Smith 19a. Informant's Name/Relationship (Typ)	a Printl	Initian Address (Chan	Lillia			
	and 2 s salth an n 27 is r er treur		Leslie B. Hughes/	Daughter 44	failing Address <i>(Street</i> 03 Raymond				
nore	Pages 1 ant of He nt: If item y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cemetery,	isposition (Name of crematory or other pla Valley Me	ce)	1	20c. Location - City Timonium,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licenses		22. Name and Addre	ess of Facility WSON Funer	al Home	. Inc.	riu.
	402 40	\vdash	23a. Part1. Enter the disease, or complic	ations that caused the death. Do no	1050_Yo	rk Rd. low	ıson. Md	. 21204	Approximate
	Pnysician /Medical	i n	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	caus on each line.	0	ell lu	mpho		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequence of)	:	-	1 1	,	
44	- E	iner	Sequentially list conditions, harry, leading to initial clusts cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of)					
0,	icate be executed physician and s the burial-transit	Examiner	that initiated events c.	Due to (or as a consequence of)					
8760,	cate be physicia the bu	dlcai	d.						_
9 x	eath certific attending p	/Me	IF FEMALE: 23	c. If yes, outcome of pregnancy				22d Data of	d=15
.O. Box	that the death ad by the atter detached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of Month	Day Year
ds, P	se og	by	Part II. Other significant conditions cont	ributing to death but not resulting in the	ne underlying cause giv	ven in Part I.			e to the cause of death?
Records,	e law requir has been s je 2 should	Completed					24a. Was a autops	y prior	autopsy findings available to completion of cause of
							perform 1 Yes 2		
Vital		Be	25. Was case referred to medical examiner?	spital:	O#	26. Place of Death			
of		on; To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tin	e of 28c. Injur	v at 2		ence 6 Other (Sow injury occurred	Specify)
Siol	Attending r death. ector: Afte by the fune	catlc	1 Natural 5 Pending 2 Accident investigation		,	Yes 2 □ No			
Division	el or Att s after d al Direct ad in by a	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	2	28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowledge, or er: On the basis of examination and/or and manner stated.	eath occurred at the til r investigation, in my c	me, date and place, a opinion, death occurre	and due to the ca	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	(1 Q a a lat	29c. Licens	se number	2	9d. Date signed (Me	SEL W
	, T		30. Name and address of person who com	pleted cause of death (Item 23a) (Tu	pe, Print)	J 2 /4	0 1	June	14m 2005
	3		Ernestine Wn 31. Date filed (Month, Day, Year)	appt WD 530	00 Dulan-	ey Valley	Road	(imani)	om 21093
	Sta Registr		JUN 1 5 200	32. Registrar's Signature	Couls				

			1 For State	State of	Maryland / De	epartment of I Certificate of		Mental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, Las	st)		erinicate or	Deam	2. Date of Death	3. No.	3. Time of Death
	Physic			Indith	F. Bradley	,		Month	Day Year	
	/Medi Examir		4a. Facility Name (If not institution, give				or Location of Death	June 1	1 . 2005 4c. County of Deat	6:40 PM M
1			4519 Chest	nut Stre	et		Bethesda			gomery
	Funeral		5. Social Security Number 6. S		Age (In yrs. last birtho		If Under 24 Hrs.	8. Date of Birth (Month, Day,)		hplace (State or Foreign untry)
	Director		223-58-3/13	UM ZAJF	63 Yrs	5	110013	January 6		lew York
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Mary I-f sh	ţō	Maryland Mont	gomerv			D . 1 1			1 ☐ Yes 2 🖾 No
	ith the Marylar or 28a-f show	Director	10e. Street and Number	gomery		10f. Zip Code	<u>Bethesda</u>	100	. Citizen of What Co	untry?
	th wil		4519 Ches	tnut Str	eet		20814			States
	r des	Funeral	11. Marital Status	12. Was Decede		13. Was Decedent of H		pecify Yes or No-	14. Race - Amer	rican Indian,
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give	ΚΊνο	1 ☐ Yes 2 🛣 No	Specify:	7 110411, 5(0.)	Black, White	e, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modell Exemples must be notified at	edb	15. Decedent's Ed	Year or Date		ecedent's Usual Occup				White
215	72 nin 72	Completed	(Specify only highest gra	de completed)	(G	live kind of work done o. DO NOT use retire	during most of work	king 16	ib. Kind of Business/I	ndustry
21	e filed within al Hygiene. I other than ' vent, Ine Ma	E O	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)	Libra	rian		Tib	rary
nd	be filed within 72 hours after death with the Maryla hal Hygiene. Id other than "natural", or items 23a or 28a-1 show event, the Marical Exeminat must be notified at	Be (17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		lary
yla	should be and Mental I marked o	2	Alm	eron Fin	ger			Thelma Ku	chenbeise	r
Maryland	01 (0) 00 00		19a. Informant's Name/Relationship (7	ype, Print)	19b. M	ailing Address (Street	and Number or Rui	al Route Number, C	City or Town, State, Z	ip Code)
	s 1 and 2 if Health item 27 l	1 6	Christopher M. Br 20a. Method of Disposition	adley/ H	usband	4519 Chest	nut Stree	t Bethesd	a, Maryla	nd 20814
οľ	Pages nent of h int: If ite		1 ☐ Burial 2 KD Cremation 3 ☐	Removal from Sta	Montgo	sposition (Name of crematory or other place mery	ce)	Date 20	c. Location - City or 1	own, State
Baltimore,			4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen		Cremat	orium Inc,	June	13,2005	Bethesda,	Mary land
Ba	permit. Departrimports any inju		1 1/2	Keslant	1100335	Bethesda.	Maryland	20814-350	())/ Wisco	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or composition of control of the co	one cause on each	sed the death. Do not h line.	enter the mode of dyin	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	a Metas	tatic Brea	st Cancer				Onset and Death 2 Years
	/Medical Examiner		resulting in death)		as a consequence of):					2 Tears
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequence of):					
	uted d ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events	(
ó	an an rial-tr	Exa	resulting in death) Last	Due to (or	as a consequence of):					
68760,	ficate be executed physician and is the burial-transit	dical Examiner		d						
	ertific ling pl e as t		IF FEMALE:			- 20				
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnancy			23d. Date of deliv	ery Day Year
o.	0 00 0	ysic	1 Yes 2 No 9 Unknown	4☐Pregnant 9☐Unknown	at time of death	5 Other (specify)			WORK	Day rear
<u>α</u>	res that the igned by th be detache	by Ph	Part II. Other significant conditions co	ntributing to death	n but not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
rds,	law requires as been sign 2 should be							1 🗆 Yes		pably 4 X Unknown
Record	law requir 1s been s 2 should	Completed						24a. Was an	24b. Were auto	opsy findings available
æ	9 1	mo:						autopsy performed	1? prior to co	mpletion of cause of
	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical				26. Place of Death	1 Yes 2X	No 1 ☐ Yes	2 U No
of <	di di	To	examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpa	itient 2 ER/Outpat	ent 3 DOA Othe			e 6 ☐ Other (Specif	(v)
		ou:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Ir (Month, L	njury 28b. Time Day Year) Injur		at	28d. Describe how i		
S	r Attend er death rector: / by the f	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
Division	or Attenater deater deater Director:	Certification;	4 Homicide determined	building,	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (Stree: City or Town, S	t and Number or Rura tate)	Il Route Number,
_	spita nours neral		29a. Certifier 1X Certifying Phy	sician: To the he	st of my knowledge, de	ath occurred at the tim	e date and place	and due to the ac-	2(a) and m	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one)	ner: On the basis and manner	or examination and/or	investigation, in my op	oinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	P N C S	7	29b. Signature and title of cerufier	1 1		29c. License	number	29d.	Date signed (Month,	Day, Year)
•	01	-		· · ·		100	> 329	5	June 13,	2005
	U		30. Name and address of person who co							
	Stat	e	Frederick P. Smith 31. Date filed (Month, Day, Year)	32. Ragis	0454 Wiscon strar's Signature	sin Avenue	#1300_CI	nevy Chase	e, Marylan	d 20815
	Registra		JUN 1 5 2	005	strar's Signature	PAR				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physici		Amend Item 1,290 1. Decedent's Name (First, Middle, I	·		timouto or		2. Date of D		00	1300
Filysici	ian	T. Docedent's Name (1 II's), Wildle, 1	Lavonne	Billing	95		Month	eath Day	Year	3. Time of Deatl
/Media		Lavonne Biillin	igs-				June			12:30 P
Examir	ner	4a. Facility Name (If not institution, g				4b. City, Town, or Lo	ocation of Dea	th 4c. Coun	ty of Death	
		Goodwill Mennon				Grantsvil		Garre		
Funeral		Social Security Number 6	. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth av, Year)	9. Birthp	place (State or For
Director		213-12-6939	83	Yrs.			Apr 15	, 1922	Mary	
2 *		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	antin					
ineo within 7.2 hours after beam with the maryland. Hygiene. wher then "natural", or items 23a or 28a-f show after then "natural", or items 23a or 28a-f show after the Medical Examiner must be notified at	_			•					1	0d. Inside City Lir
88-f	Funeral Director	MD Garre	ett	Grants	ville					1☐Yes 2√2
2 2	훒	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
238	a	819 Dorsey Hote	1 Road			21536		IIC	۸.	
§ E 3	ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U,S. 13. \	Was Decedent of I	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No	US/ 0- 14. Ra	ce - Americ	
2 3 3	교	1 Never Married 2 Married	1 Yes 2 No				Hican, etc.)	Bla	ack, White,	etc.
E. B.	ρ Ω	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2∏No	Specify:		Speci	^{fy:} whi	lte
"natural",	Completed	15. Decedent's	Education	16a. Deced	dent's Usual Occup	pation		16b. Kind of E	Business/Inc	dustry
2	음	(Specify only highest g		(Give	kind of work done DO NOT use retire	during most of work	ing			,
t a	E	Elementary/Secondary (0-12)	College (1-4or 5+)	boo	kkeeper			Corps o	f Eng	incerc
Hyg ther	Ö	17. Father's Name (First, Middle, Las	st)	, , ,	renceper	18. Mother's Name	First Middle			Heers
ed c	Be c	Joseph Carr	,			Nella Koo		, maiden opina	110)	
and Mental Hygi Is marked other aumatic event, I	2	-								
is n		19a. Informant's Name/Relationship				and Number or Rura			, State, Zip	Code)
of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical		Brian Forney/son				d Grantsv	ille, M	1D 2153	6	
프를		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		 Place of Dispose cemetery, cren 	sition <i>(Name of</i> natory or other plac	ce)	Date	20c. Location	- City or To	wn, State
ing in the line of		4 ☑ Donation 5 ☐ Other (Spec								
Department of Important: If it any injury or once.		21. Signature of Funeral Service Lice Ronald S	ensee	22	, Name and Addre	ss of Facility	1 (55 -			a .
Depa Impo any ir		Ronard S.	wade, pirect		State Ana	ss of Facility Comy Boar	d 655 1	W. Balt:	lmore	Street
		/ Suran	////		Baltimore					
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mpications that eaused the de y one cause on each line.	eath. Do not ente	er the mode of dyir	ig, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between
nysician	1		Λ		D				1	Onset and Death
Medical aminer		Immediate Cause (Final disease or condition	a ASPIRA-	MOIT	PNEUI	AIMON	•			Lulook
		resulting in death)		o (or as a conseq						1 0000
æ	<u>=</u>		, NEURO	GEN	IIC P	JUSPHA	GIA			>544
rans	a a	Sequentially list conditions.	U	(or as e consequ			017.7			1 3 9 43
an ar nial-t	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or inlury	0	rovas	A .	Accio	la.t	40		STU
physician and s the bunal-transit	Medical Examiner	that initiated events	4	(or as a consequ		ricao	wy		115 -11 -12	771
as th	짱	resulting in death) Last	Α.		,	T				
ip es		•	a DIABET	ES	MELLI	145.			-	Syr
attendir I for use	Physician/I									1
chec	ysi	Part II. Other significent conditions			iderlying ceuse giv	en in Part I.	23b. Did	tobecco use co	ntribute to	the cause of de
ed by deta	듄	Kenal far	lure.				10	Yes 2⊠No	3 Prob	ably 4 ☐ Unkr
	by		lune. DEMENTI							
should t	Completed	Adromosal	DEMENTI	A.			24a. Was perfo	an autopsy rmed?	ava	re autopsy findin ilable prior to
as b	ᆲ		- 01101317						com of d	npletion of cause leath?
te ha	Ö						101	Yes 2. № No	1 🗆	lYes 2□ No
iffica tor, p		25. Was case referred to medical				Of Dian of David		•		1165 2010
irect	a	examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Oth	26. Place of Death				
rald	- To	27. Manner of Death	1 Inpatient 2		3LI DOA	4 Nursing Hon)
After	<u>.</u>	1 KNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl		.ou. Describe i	now injury occur	rea	
the the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to	26			Yes 2 □ No				
irec n by	튄	4 ☐ Homicide determined		home, farm, stre	et, factory, office	2	8f. Location (8) City or Tov	Street and Numb vn, State)	er or Rurai	Route Number,
ed in	Certification:									
		29a. Certifier 1 ☐ Certifying Pi	hysician: To the best of my ki	nowledge, death	occurred at the tim	e, date and place, a	nd due to the	cause(s) and ma	anner as sta	ited.
uner aly fill	ed:	one)	miner: On the basis of examination and manner stated.	nation and/or inve	estigation, in my op	oinion, death occurre	d at the time,	date and place,	and due to t	the cause(s)
ne Funer ne Funer pletely fill		29b. Signatore and title of certifier			29c. License	number		29d. Date signe	d (Month, D	lay, Year)
n 24 hou he Fune pletely fi		D Val In A A	laurals	MD	D0586	555		6/71	05	
To the Funer Completely fill		WILLIAM FOLLOW						F 1 4 1 1		
To the Funer completely fill		20 Name and address (C)0000000					7/		
To the Funer completely fill		30. Name and address of person who			Print)			0 / /		
To the Funer Completely fill		30. Name and address of person who Sabahat Nawab, 31. Date filed (Month, Day, Year)		Dr. G	Print)		36	9/ //		

DHMH 16 Rev 6/95

			1 - For State Registrar	State o	of Mary	land / Dep <i>Ce</i>	artment o <i>rtificate d</i>	f Hea	alth ar eath	nd Menta		ene ())5	198	90
			1. Decedent's Name (First, Middle	e, Last)							te of Death			3. Time o	of Death
	Physici /Medio		Karoline E.	lisabeth	Brow	m					e 11,	Day 2005	Year	2:30	O D M
}	Examir		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Tow	n, or Lo	cation of			4c. County	of Death		у р
			Chapel Hill	Nursing C	enter		Randa	11st	own			Balt	imore		
	Funeral		5. Social Security Number	6. Sex		yrs. last birthday,	If Under 1 Yo	ear If	Under 24	4 Hrs. 8. Da	te of Birth onth, Day, Y		9. Birtho	lace (State	or Foreign
L	Director		219-32-4121	1□M 2√2F	8	9 Yrs.	IVIOTILIS DE	iys	Tours		. 8,		Ger		
	pu »		Usual Residence of Decedent 10a. State 10b. County		140	c. City, Town or L	4:								
	aryla sho	<u>~</u>			"								1	0d. Inside (,
	88-1	Director		imore		Randall									s 2/2 No
	with t	ä	10e. Street and Number				10f. Zip Cod				100	g. Citizen of	What Coun	try?	
	s 23c	rai		on Road			2113					U.S.A			
	er de Item	Funerai	11. Marital Status	12. Was Dec	orces?	r in U.S. 13.	Was Decedent If Yes, specify (of Hispa Cuban, N	inic Origir Mexican, F	n? (Specify Ye Pu <i>e</i> rto Rican,	etc.)		ce - Americ ck, White,		
36	s within 72 hours after death with the Maryland Jiene. r than "naturel", or Items 23a or 28e-1 show The Madical Examiner must be motified at	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ∐Yes If Yes, Gi Year or D	AND NO		1□ Yes 2√x	No S	ipecity:			Specif	v: Whi	to	
9	hou		15. Decedent		,a(63.	16a Dece	dent's Usual Oc	cupation	n		16	Sb. Kind of B			
15	in 72 n "na Abdis	Completed	(Specify only highes	it grade completed)		(Give	kind of work do DO NOT use re	one durir	ng most o	of working	10	DO. KING OF B	u3111655/1110	lustry	
72	iene. r than "	E	Elementary/Secondary (0-12) 8th. Grade	College (1-4or 5+)	_	mstress	·				Cloth	ina		
D	T the	Be C	17. Father's Name (First, Middle,	Last)				18.	. Mother's	s Name (First,	Middle, Ma				
an		ToB	Johann I	Heinrich	п	ahlmann		A	nna	E	leano	r	Horr	oi c	
Maryland 21215-0036	2 should be and Mental Is marked or aumatic eve	-	19a. Informant's Name/Relations		D		ng Address (Str								
	nd 2 lith a 27 is		W. Michael Se	eganish/G	ıardi	an 60	6 Balti	more	Ave	nue Su	ita20	2 Ral+	imore	MD	21204
Baltimore,	s 1 a f Hes item othe		20a. Method of Disposition		2	Ob. Place of Dispo	osition (Name of matory or other	f	1100	Date		c. Location			21204
9	age ent o nt: #		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S)			ardens o				/14/20	0.5	D = 1 + 4		MD	
≣	artm orter injui		21. Signature of Funeral Service									Balti	more	MD	
ä	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked any injury or other traumatic e once.			15			Charle	s S.	Zei	ler& S venue	on, In	nc.	MD	21224	
			23a. Pert1. Enter the disease, or shock, or heert failure.	complications that	aused the	death. Do not en							FID	Approxima	te
	Physician		Immediate Cause (Final	only one cause on a		heimen								Interval Be Onset and	
	/Medical		disease or condition resulting in death)	a		onsequence of):	13 0	1>0	436	_					
н	Examiner			1	(0) 43 4 00	risoquorico (1).									
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8760,	icate be executed physician and s the burial-transit	dicai		d											
9	tifica ng ph as th	edi	SI												
Box	death certifi e attending p id for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			75-tonio					23d. Da	te of delive	у	
	death e atte ad for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□ Pregr	nant at time]Ectopic pr eg na] Other (s <i>pecif</i> y					Mo	nth	Day	Year
P.O.	requires that the de een signed by the a hould be detached t	Physician/Me	9 Unknown	9□ Unkn	own										
	ss tha	by F	Part II. Other significant condition	ns contributing to d	eath but no	ot resulting in the u	nderlying cause	given in	Part I.	23	e. Did tobac	cco use cont	ribute to the	e cause of	death?
ğ	w require been sig should b									_ 11	1 🗌 Yes	2 🗌 No	3 Proba	ıbly 4 🛭	Unknown
Vital Records,	s bee	Completed								24	a. Was an	24b. 1	Vere autop	sy findings	available
R	The law ate has b page 2 sl	mo								_	autopsy performe	d? !	prior to con death?	pletion of d	cause of
ta		BeC	25. Was case referred to medical		·			26	Place of	f Death (Chec		No	☐ Yes	2 L No	
		ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient	2 ER/Outpatier	nt 3□ DOA	0.4		ing Home 5		e 6∏Oth	or /Spacify	,	
0	ig Phys ter this neral di		27. Manner of Death	28a. Date	of Injury	28b. Time o		njury at Nork?	, , , , , , , , , , , , , , , , , , , ,			injury occuri			
Division of	를 는 조 글	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	9	th, Day Ye	ar) Injury			2 □ No	,					
<u>S</u>	f or Attendin after death. Director: Af in by the fur	ifica	3 Suicide 6 Could n	ned 280. Place	of Injury -	At home, farm, str	eet, factory, offi	ce		28f. Loc	ation (Stree	et and Numb	er or Rural	Route Nun	nber,
Ö	el or s afte	Certification:	4 Homicide	Bulla	ng, etc. (S	рөспу)				City	or Town, S	State)			
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physician: To the	best of m	y knowledge, deat	occurred at the	e time, d	late and p	place, and due	to the caus	se(s) and ma	nner as sta	ited.	
	he Hin 24 he Fu	Medical	(Check only 2 Medical I	examiner: On the b	asis of exa ner stated.	mination and/or in	vestigation, in m	ny opinio	n, death	occurred at th	e time, date	and place,	and due to	the cause(s	s)
	Tot withi Totl	Σ	29b. Signature and title of certifier	Λ .			29c. Lic					. Date signed			
	1		Marien of	palri	(, M	, D.	D	00	586	76	70	100	3,2	005	
1	16		30. Name and address of person v	who completed caus	e of death	(Item 23a) (Type,	Print)								
1	<i>L</i> '		Karen L. Bal	sitt, Mi	0., 2	5 Main	street	, 50	1170	200,	Reiste	1360	un, M	1021	136
	Sta		Caren L. Bal 31. Date filed (Month, Day, Year) JUN 152	DOE Je. F	egistrar's	Signature	40								
	Registr	ar	JUN 1 5 Z	UUD CUU.	we s	O Good	w								
DH	MH 17 Rev 1/20	001													

	ın	AGNES			per 1			ART			2. Date of D Month	Da	200	Year	3. Time of De
/Medica	71	4a. Facility Name (If not in	stitution, giv	e street and num	iber)	-1 ^			Location	of Death	STORE		c. County of		0/0/
		The John	12 HOF	DUNS	HOSPI	tal	Ba	11	more	2	City		NA		·
Funeral Director		5. Social Security Number 217–54–214		Sex I□M 2【X】F	7. Age (<i>III</i>) yrs. I: 55	la <i>st birthd</i> ay, Yrs.	Months Months		If Under Hours	24 Hrs. Min.	8. Date of B			Coun	
AII COLOI		Usual Residence of Deced							L		10-1	1-49)	Mc	i
or 28a-f show	_	_	County		10c. City	, Town or L								10	0d. Inside City I
28a-f	Director	Md.	NA			Bal	timor								X□Yes 2
23a or			ا مددات	Chan a t			10f. Zip		010			10g. Ci	tizen of Wh		try?
items 23	Funerai	1919 E. Fe	derai	12. Was Deced	dent Ever in U.S	S. 13.	Was Deced		213 Ispanic Ori	gin? (Spe	acify Yes or N	0-	US.		an Indian
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fur	1√ Never Married 2 3 ☐ Widowed 4 ☐ Di	_	Armed Ford 1 Tes 2 If Yes, Give	ZX No	1	If Yes, spec		n, Mexicar Specify:		ecify Yes or N Rican, etc.)			White, 6	etc.
"natural", or	ted t	15. De	ecedent's Ed		tes:	16a. Dece	dent's Usua	al Occupa	ation			165 K	(ind of Busin		
Med ".	Completed		highest gra	de completed) College (1-	4or 5+)	(Give	kind of wor DO NOT us	rk done o	turina mos.	t of worki	ing	100. 1	and or busin	ness/ind	ustry
artha d	E O	llth grade		Conege (1-	401 34)	C	ook					Re	staur	ant	
e van	Be	17. Father's Name (First, A	Middle, Last)						18. Mothe	r's Name	(First, Middle				
armatic evant, the M	၉	James			arter					rene				rter	
7 is n	4	19a. Informant's Name/Re									I Route Numb			ate, Zip	Code)
Important: If itam 27 any injury or other tr.	-	Daine Poole 20a. Method of Disposition		Sist		4009 ace of Dispo	WILSI sition (Nan	Dy A	ve.,		imore,		212 ocation - Cit		un State
y or o	1	1 Burial 2 Crem			tate ce	ametery, crei	matory or o	ther place	· 1						
Important: I any injury o		21. Signature of Funeral S		•	VOS	shell i	Mem. (6–17 v	-05 Balti		undall		d. 202
any ii) Bla	dono	War	Casa				H. Ea	,			North		
sician ledical		Immediate Cause (Final disease or condition resulting in death)	e. List only	a. POOR	LY DI	FFEA					r respiratory a				Onset and Dea
ledical aminer tisl-transit	Examin	Immediate Cause (Final disease or condition		a.	GI IIII e.	ence of):									Interval Between Onset and Dea
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ha Funaral Diractor: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit of pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit of pletely filled in the formal filled in the formal complete of the formal filled in the filled in the filled in the filled in the formal filled in the filled in the filled in the formal filled in the fille	regical certification; To be completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enser unuerying Cause, (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown Part II. Other significant conditions in the past 12 months 1 Yes 2 No 9 Unknown Part II. Other significant conditions in the past 12 months 1 Yes 2 No 9 Unknown 25. Was case referred to mexaminer? 1 Yes 2 No No No No No No No	ant ?? pending needical Pending needical Could not be determined ortifying Physicial Exemptons and the could not be determined ortifying Physicial Exemptons and the could not be determined ortifying Physician Could not be determined or the could n	a. Pool Due to (of b. Due to (of c. Due to (r as a consequence of as a consequence of pregnant 2 Fetal on the at time of dearent at t	ence of): ence of):	DEctopic present of the state o	egnancy ecify) ause given ause given ause given ause given ause given ause given ause given ause given ause given ause given ause given ause given	n in Part I. 26. Place 7. 4 Nur at 9. date and nion, deatt	of Death sing Hom 2	23e. Did t 1 1 2 24a. Was autop parto 1 1 Yes (Check only of the 5 Resided Reserv	obacco u Yes 2 an obsy primed? 2 No one) dence (now injury cause(s) date and 29d. Date	Month use contribu No 3 24b. Wer prior deat 1 6 Other (2 y occurred d Number o and manne place, and	of delivery The state to the state of the s	interval Betwee Onset and Dead Value Cause of death bity 4 Unkr by findings available of cause In No

		For State Registrar	State of Maryland	/ Depa		and M	dental Hyg	_	05 989
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, JAH) 4a. Facility Name (If not institution,	MAL LAMON	1+	CARTER 4b. City, Town, or Location	on of Death	2. Date of Dea Month June 9,	Day 2005 4c. County	Year 3:25 P
Funeral Director		Upper Chesapeake 5. Social Security Number 140 • 58 • 6528 Usual Residence of Decedent	Medical Center 7. Age (In yrs. las	t birthday) Yrs.	Bel Air If Under 1 Year If Uncomonths Days Hour	ler 24 Hrs. s Min.	8. Date of Birth	Harfo 1969	9. Birthplace (State or Fore NEW TERSE
he Maryland 28a-f show	ector	10a. State 10b. County	10c. City, 7		MORE				10d. fnside/City Lim 1 🗹 Yes 2 🗆
eath with the 23s or 2	eral Dir	10e. Street and Number 629 MC K	EWIN AVE. 12. Was Decedent Ever in U.S.	13.1		1218 Origin? (Sp		10g. Citizen of V	what Country? S.A. ee - American Indian,
1215-0036 within 72 hours after death with the Maryland ene. then "naturel", or Itame 23s or 28s-1 show the Modest Exercities of the Modest Exercities at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic f Yes, specify Caban, Mexi I ☐ Yes 2 ☐ No Speci		Rican, etc.)	Specify	ck, White, etc.
d 21215-0036 filed within 72 hours alf Hygiene. ther then "naturel; or ant, the Modes Exert	Complete	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Deced (Give life. I	lent's Usual Occupation kind of work done during mo OO NOT use retired) ATEREK	ost of work	ing	_	usiness/Industry
Maryland 212: td 2 should be filed within the and Mental Hygiene. 77 is marked other then treumatic event, the Mental Hygiene.	To Be (17. Father's Name (First, Middle, La JOSEPH 10. Information Name (Polatication)	CARTER	105 14 17		DA	e (First, Middle, TRICIA	MA	RSHALL
timore, Ma t. Pages 1 and 2 straint of Health ar rient: If item 27 is		19a Informant's Name/Relationship PATRICA CAR 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice	TER (MOTHER) 20b: Place cem Colly) 20b: Place cem MORE	429 te of Dispo tetery, cren	g Address (Street and Nun MC KEVIN sition (Name of natory or other place) COMBLEXY . Name and Address of Far	WE 6-2	1	TIMURE 20c, Location -	
Physician /Medical Examiner	85	23a. Part 1. Enter the disease, or constant failure. List or fmmediate Cause (Final disease or condition resulting in death)	omplications that caused the death. If yone cause on each line. Acrica	i Di	905 YORK er the mode of dying, such	ROAD as cardiac		IMOKE,	ADD 2/2/2 Approximate Interval Between Onset and Death
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.						
that the death certificate to by the attending physic detached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deati	ath 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of delivery nth Day Year
COTGS, P wrequires that been signed b should be deta	Completed by Pt	Part If. Other significant conditions	s contributing to death but not resulting	ng in the ur	ndertying cause given in Pa	rt I.	1 🗆 Y	es 20 No	ribute to the cause of death? 3 Probably 4 Unkno
OT VITAL HECONDS, Physician: The law requirest this certificate has been signe tral director, page 2 should be	Be	25. Was case referred to medical examiner?				ice of Death	24a. Was a autops perform	sy med? 2□No 1	Were autopsy findings availa prior to completion of cause of teath? Yes 2□ No
In OT ng Phy Ater this Ineral d	Certification: To	27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	28a. Date of Injury (Month, Day Year)	VOutpatien Bb. Time of Injury	28c. Injury at Work? M 1 Tyes 2	□No	me 5 Reside 28d. Describe he 28f. Location (Si City or Town	ow injury occurr	
DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Check only one) 1 ☐ Certifying 2 ☒ Medical Ex	Physician: To the best of my knowle aminer: On the basis of examination and manner stated.	edge, death	occurred at the time, date restigation, in my opinion, d	and place, a	and due to the c	ause(s) and ma	nner as stated. and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier Annels House	than 11 min		29c. License numbe OCME	r		9d. Date signed	1 (Month, Day, Year)
HAI	ate.	30. Name and address person where E. Su 31. Date filed (Month, Day, Year)	to completed cause of death (Item 23) (Uha), M) 32. Registrar's Signature		dil Penn Str	eet]			land 21201
Registi	ar	JUN 15	2005 Jean #						

			1 - For State Registrar	State of	Maryla		artmen rtificat			and M	ental Hyg	iene	005	19892
	Physic /Medi		Decedent's Name (First, Middle, La ANDREW CHRISTOPH	IER COLL							2. Date of Deat Month	Day	Year 2005	3. Time of Death 9:08 a M
	Examir	ner -	4a. Facility Name (If not institution, giv Washington Adver					Town, or	Location o	f Death			nty of Deat	
	Funeral Director		5. Social Security Number 6. S 219-68-3306			. last birthday) Yrs.		1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, March 8	Year)	9. Birtl	pplace (State or Foreign untry) Shington, DC
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23s or 28s-1 show any injury or other traumatic evant, the Madical Evantment the notified at ODGs.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 5712 Vassar Drive 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Et. (Specify only highest grave) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Philip LeRoy Coll 19a. Informant's Name/Relationship (Margaret R. Colli 20a. Method of Disposition 1 Burial 2 X Cremation 3 A Donation 5 Other (Specify 21. Signature in Funeral Service Licen	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dail lucation de completed) College (1	dent Ever in topes? 2 🖾 No stes: 4or 5+)	16a. Decer (Give life.) Resta 19b. Mailir 5712 Place of Dispo cometery, crar tropoli	Park 10f. Zip 20 7 Was Deced If Yes, specific Yes, spec	740 Jent of History Cuban All Occupants done of the retired, (Street a ar Dr. pa of the place of daddress	specify: tition uring most 18. Mother Marga nd Number rive, cory (s of Facility	of working of working of some of the sound o	cify Yes or No-Rican, etc.) Raese Route Number, Lege Par ate 2005 Sch's Fu	U.S. A 14. E Spe 16b. Kind o Kenwo faiden Sum City or Too k, Ma 20c. Locatic Alexa meral	Acce - Americal American State, White Society: What such a society and such as a such	incan Indian, a, etc. ite Industry untry Club ip Code) d 20740 Town, State , Virginia , P.A.
8760,	Physician /Medical Examiner the printer transit	ıi Examiner	23a Patt1. Enter the disease, or companded, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or	r as a consecurate as a	th. Do not ent					respiratory arre		, 115	Approximate Interval Between Onset and Death
P.O. Box 6	the death certifii y the attending p iched for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnar 9□ Unknow	th 2 🗍 Feta nt at time of d vn	al death 3 death 5 death	Ectopic pre Other (spe	ecity)	n in Part I.		23e. Did toba	P	Date of deliv	Pery Day Year
Records,	v requi	Completed b									1 ☐ Yes	2 □ No		bably 4 Munknown
	(0	a	25. Was case referred to medical						OS Plans	of Dooth	autopsy perform 1 Yes 2	ed? X No	prior to co death?	ompletion of cause of
oţ	tending Physicath. tor: After this the funeral dis	Certification; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of (Month,	Injury Day Year) f Injury - At h	ER/Outpatien 28b. Time of Injury	28 M	Bc. Injury Work:	~ 4 □ Nurs	sing Hom 28	e 5 Resider	nce 6 □C v injury occ	urred	fy) al Route Number,
Ď	in the		29a. Certifier 1 X Certifying Phy	building	est of my kno	(y)	occurred a	at the time	, date and	place an	City or Town,	State)	Manner ac a	totod
	To tha Hospital within 24 hours a To tha Funaral to completely filled	Medical	(Check only 2 Medical Examone) 295. Signature and title of certifier	iner: On the bas	s of examina	ation and/or inv	estigation,	License	nion, death number	occurred	d at the time, dat	e and place	e, and due to ned (Month,	Day, Year)
6			30. Name and address of person who o	ompleted cause	of death (Item	п 23а) (Туре, І	Print)	5	20.	>	~	uno	13	2005
N .	Sta Registr	te	Stephen M. Smith, 31. Date filed (Month, Day Year) 1.	MD 921	0 Corp	oorate	BLVD	Ste	#210 ,	Roc	kville,	Mary:	land	20850

			1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of Health and Mertificate of Death		ene2005	19894
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	/Medic	cal	Boyd Sevier Campbell		June 9,	2005	9:45 a M
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		6315 Jason Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cheverly If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	place (State or Foreign
	Director		579-01-8812 1X M 2□F 88 Yrs.	Months Days Hours Min.	(Month, Day, Y March 23,	1917 Mis	intry) Souri
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	ocation			10d. Inside City Limits
	a-f sh	ctor	Maryland Prince George's Cheverly	,			1X Yes 2 No
	ith the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	untry?
	s 23a		6315 Jason Street	20785		U.S.A.	
' 0	fter de	Funeral	11. Marital Status 12. Was Decadent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	city Yes or No- lican, etc.)	14. Race - Amer Black, White	
93	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
2	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Medical Ever'il at mark its righted at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	g 16	b. Kind of Business/li	ndustry
12	withir iene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Ve	erizon Tel	ephone Co.
פַ	be filed ntal Hygie ad othar	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			ephone do.
<u>ylar</u>	should by	ToE	Sevier Campbell	Nellie Mo	Pherson		
Mar	d 2 sh h and 7 la m traum			ng Address (Street and Number or Rural			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If itam 27 Is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Ever's ser must be redified at ODC8.		Henrietta Campbell - Wife 6315 20a. Method of Disposition 20b. Place of Dispo	Jason Street, Chevasition (Name of partition) Date of partition of their place)		aryland 20 c. Location - City or T	
E	Pages ent of nt: If i		A Dutial 2 Communion 3 Chemoval non State	natory or other place) coln Cemetery 6/15/	/2005 B ₁	centwood.	Marvland
ati	apartm aporte ny inju			2. Name and Address of Facility Gaso			
	20189			4739 Baltimore Ave.			
k	ar 0.		23a. Part . Enter the disease or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			,	Approximate Interval Between Onset and Death
i	Pnysician /Medical		disease or condition resulting in death) a	uimonary arre	sl		
	Examiner		Sequentially list conditions b Cononay	artey Discar	e		12 years
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				0
_,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			-	
8760	ysicial	dical	d				
9		Med	IF FEMALE:				
Box	eath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of deliv Month	rery Day Year
o.	at the de by the a tached	nysid	1 Yes 2 No 4 Freguent at time of death 5 9 Unknown	Other (specify)			
o,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
ord	equire sen sig		- Caucer of the prostat - Chronic brain spe	e	1 🗆 Yes	2 □No 3 □ Pro	bably 4 \(\sum \) Unknown
Records,	has by	Completed	- Chionic brain spe	drome	24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of
Vital	ilcian: The certificate ha	e Co	25. Was case referred to medical		1 □ Yes 2X		2 🗆 No
	yaician; s certific director,	0	examiner? 1 \subseteq Yes 2 \subseteq No Hospital: 1 \subseteq Inpatient 2 \subseteq ER/Outpatien	26. Place of Death (t 3 □ DOA Other: 4 □ Nursing Home		e 6 □Other (Speci	6(1)
Division of	ding Phys h. After this funeral di	J: Jug	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury 28b. Time of Injury		d. Describe how		
Sio	Attendii death. ctor: A y the fu	catle	2 Accident investigation	M 1 Yes 2 No			
	l or Al after d Dirac	Certification:	4 Homicide determined determined determined	eet, factory, office 28	If. Location (Stree City or Town, S	t and Number or Run itate)	al Route Number,
	ospite hours unaral y fillec		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, an	d due to the caus	e(s) and manner as s	stated.
	To the Hospitel or Attending Physician: within 24 hours after death To the Funaral Diractor: After this certific completely filled in by the funeral director.	Medical	(check only one) 2 Medical Examiner: On the basis of examination and/or interpretation one) and manner stated.	estigation, in my opinion, death occurred	1 at the time, date	and place, and due t	o the cause(s)
	with Con Con	2	29b. Signature and title of certifier	29c. License number		Date signed (Month,	-
î	11		30. Name and address of person who completed cause of death (Item 23a) (Type,	D 000 8520)	6/13/05	
(50				-6, Green	nbelt, Mar	yland 20770
	Sta		Thomas J. Hernandez, MD 7525 Greenward of the filed (Month, Day, Year) N 1 5 27 Progistrate Signature	Sporte		_,	
	Registr	ar	And the second second				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician Ronald Cousins** 6:25 p Jun 5, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis-Cromwell Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ★M 2 F Director 217-54-0180 55 Mar 3, 1950 Md Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location d other then "netural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Baltimore Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1922 Woodbourne Avenue 21239 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: à Black 3 ¥ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne any injury or other treumatic event, II a Media 2008. Elementary/Secondary (0-12) College (1-4or 5+) Skilled Worker Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Trusty Rosie L. Cousins 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosie L. Cousins Mother 1922 Woodbourne Avenue Baltimore, Maryland 21239 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Metro 6/10/2005 Baltimore, Md 21. Signature of Fune al Service 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ardvac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit өхөс Due to (or as a consequence of): P.O. Box 68760 the attending physician pe Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Thknown Completed been 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2□ No 1 Yes 2 D N or Attending Physicien: after death. Director: After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes /2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) uneral 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: aturai 5 Pending investigation 1 Yes 2 No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funerel L pelli Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 00059855 ess of persen who completed cause of death (Item 23a) (Type, Print) 601 32. Registrar's State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Jun 7, 2005 10:50 p Lee C. Carter, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Rock Glen Nursing & Rehab. Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day Birthplace (State or Foreign Country)
 N. C. **Funeral** 1 ☑ M 2 ☐ F Month, Day, Year) Jan 30, 1929 **Director** 220-24-3679 76 Usual Residence of Decedent with the Maryland od other then "natural", or items 23a or 28e-f show event, the Medical Examiner must be rediffed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Yes 2□No N/A Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2467 Westport Street 21230 U.S.A death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. iii. Pages 1 and 2 should be filed within 72 hours atter effects of Health and Mental Hygiene. effant: if item 27 is marked other then "natural; or ite miury or other traumatic event, the Medical Eagle. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Industrial Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elnora C. Thompson Lee Carter Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2467 Westprot Baltimore, Md. 21230 Raynell Gladden Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/14/05 Catonsville, Md. 1 4 □ Donation 5 □ Other (Specify) Metro Cremetary permit.
Departri 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Estep Brothers Funeral Service PA
1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Metas la hic disease or condition resulting in death) 6ladder yrars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Month Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) detached ☐Yes 2☐No The law requires that the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 99 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan this certificate has page 2 autopsy 1 Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: P 1 Yes 2 No dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Jursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After the Hospital or Attending Natural 2 Accident 5 Pending investigation 2 No within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 6 Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Pelli 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 743386 6.13.05 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R EUNW Howard Place 1714 Buthran 31. Date filed (Month, Day, Year) JUN 15 egistrar's Signature State 2005 Registra

			1 - For State Registrar	State of Ma	aryland		artment o				jiene	2001	1989.
	0.		1. Decedent's Name (First, Middle, Last)						2. Date of Dea	th		3. Time of Death
	Physic /Medi		MARIE CRADDEN							Month June 1	Day	2005	3:00 P M
	Exami		4a. Facility Name (If not institution, give				4b. City, Tow	n, or Location		<u>Julio</u> 1		County of Dea	ath
			1110 Daniels Av					nsvil		anor	E	Baltim	ore
	Funeral		5. Social Security Number 6. Se 217–38–7148	x 7.Ag]M 2]X[]F	e (In yrs. last	t birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birth (Month, Day)	Year)	9. Bir	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		91_	115.			ز	July 1,	191		land
	aryland show		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
	Mar st	tor	Maryland Baltimore)	Car	tona	ville	Manar					1 ☐ Yes 2√ No
	or 28	Directo	10e. Street and Number	-	Ca	COIIS	10f. Zip Cod			1	0g. Citi	zen of What C	ountry?
	hours after death with the Maryland turel', or Items 23e or 28a-f show all Exercitive fourtible at setting of		1110 Daniels Ave	enue			212	07			Uni	ted St	tates
	ar dez	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Yes, specify C	of Hispanic Ori	igin? (Spec	ify Yes or No-		14. Race - Ame Black, Whi	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	10		I□Yes 2X71			, 5.5.7		Specify:	
응	Jwithin 72 hours Jiene r then "neturel", I're Medical Eve		15. Decedent's Edu	Year or Dates:	1 1	60 Doord	lent's Usual Oc	avantia.			121 12	Wn	ite
15	within 72 ene. then "net	Completed	(Specify only highest grad	e completed)		(Giva	kind of work do OO NOT use rei	ne durina mos	t of working	9	16b. Ki	nd of Business	/Industry
212	d with giene. r ther	E O	Elementary/Secondary (0-12)	College (1-4or 5	S-1	eamst		,		τ	Depa	rtment	Store
b	be filed ttal Hygi id other event, t	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Middle, M	<i>Maiden</i>	Sumame)	
<u>la</u>		ToE	Bernard Brown						e McCa	4			
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (Ty		, 1	19b. Mailin	g Address (Stre	eet and Numbe	er or Rural	Route Number,	City or	Town, State,	Zip Code) 21784 _
	l and lealth m 27		J. Collette Los	karn-Dau	ghter	1593	Homelar	nd Driv	e, Ur	it 1A,	Syk	esville	e, Maryland
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1	lemoval from State	20b. Place	e of Dispos etery, crem	sition (Name of natory or other p	olace)	Da	te	20c. Lo	cation - City or	Town, State
Ħ,	t. Pa tmen tent: ijury		`4 Donation 5 □ Other (Specify)		Wood		Cemeter			4, 05 E	Balt	imore,	Maryland
Bal	permit. Pages Department of I Importent: If it eny injury or o	J. I	21. Signature of Funeral Service Licens	ber CF.	SPLF	Da 53	Name and Add Vid J. 11 Fdmc	dress of Facility Weber	Funer	al Home	es,	P.A.	land 21229
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused ne cause on each lin	the death. D	Do not ente	r the mode of o	tying, such as	cardiac or	respiratory arre	est,	PICILY	Approximate Interval Between
	Physician -		Immediate Cause (Final disease or condition	Dia	bete:	S	Mel	(1tus	<				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequenc	ce of):		1100	2				year 5
	LXdiffiller	_	Sequentially list conditions,										
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequenc	ce of):							
	and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a	consequenc	ce of):							
8760,	cate be executed bhysician and the burial-transit	dical E											
687	tificate ig phy: as the												
Вох	eath certifi attending for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of							1 2	3d. Date of deli	iron
m.	that the death led by the atter detached for	icia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pregnar Other (specify)	тсу				Month	Day Year
P. 0	t the by th	hys	9 Unknown	9∐ Unknown									
S,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	Part II. Other significant conditions con	tributing to death bu	rt not resulting	g in the <i>u</i> nd	derlying cause	given in Part I.		23e. Did tob	acco us	se contribute to	the cause of death?
Ď	w require been si should b									1 🗌 Ye	s 25	No 3□Pr	obably 4 Unknown
Records,	has be	Completed								24a. Was an		24b. Were au	topsy findings available
		Corr								autopsy perform		death?	completion of cause of
Vital	Attending Physician: Thr death, sctor: After this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death (6	Check only one	-		20110
	Physion this cal direct	P	1 ☐ Yes 2 No	ospital: 1 Inpatien		Outpatient	3□ DOA	other: 4 🗆 Nur	rsing Home	Resider	nce 6	Other (Spec	city)
Ë	ding Ph h. After th tuneral	on:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b	. Time of Injury		ork?	280	d. Describe hov	w injury	occurred	
S	ttend death tor: / the f	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					□Yes 2□N					
Division of	l or Attenc after death Director: in by the	Certification:	4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, . <i>(Specify)</i>	farm, stree	et, factory, offic	0	28f	Location (Stre City or Town,	et and State)	Number or Ru	ral Route Number,
_	spitel ours a nerel filled		29a. Certifier Certifying Phys	ician: To the best of	f my knowled	do dooth	Occurred - 4 2	41	1 -1 -				
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physical Certificity Physical Certificity Phys	er: On the basis of and manner state	examination a	and/or inve	occurred at the estigation, in my	time, date and opinion, deatl	place, and h occurred	due to the cat at the time, dat	use(s) a te and p	and manner as place, and due	stated. to the cause(s)
	ro thi	Me	29b. Signature and title of certifier	///			29c. Lice	nse number		29	d. Date	signed (Month	, Day, Year)
}	1		Jounflust.	into n	0		10	5101	8				
1-	11/	-	30. Name and address of person who con	mpleted cause of de	ath (Item 23a	a) (Type. P	rint)				-1	, , , , ,	
0	V		Douglas Pint 31. Date filed (Month, Day, Year)	32. Registrar	34-	21 6	senson	Ave	. E	Baltin	ndv	e, N	5 10 21227
**	Stat Registra	- 4		2005 Aedistrar	s Signature	4 6	Colle						

State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death	Reg. No.	00 19898
	Physic	an	Decedent's Name (First, Middle, Last)		2. Date of Deeth Month Day	3. Time of Death
	/Medi		Thomas Pavia, HE		$G \cdot G'$	05 739m
7	Examir	ner :	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		ty of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last.	1 200	MORE	NIA
	Funeral Director		215-82-7155 12M 20F 43	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) APRIL OI, 1962	9. Birthplace (State or Foreign South)
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	-	10d. Inside City Limits
	Ba-f sho	ctor	MARYLAND N/A	BALTIHO	RE CIT	1/ 1/OYes 2□No
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hygiene. Important: if item 27 is merked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be invitted at once.	Funeral Director	10e. Street end Number 2103 N. PULASKI S	10f. Zip Code 2 /2 /	10g. Citizen of	What Country?
	eep .	ner	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	ace - American Indian, ack, White, etc.
Maryland 21215-0020	urs afte al', or it Examin	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☒No Specify:	Speci	
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	Se. Decedent's Usuel Occupation (Give kind of work done during most of worki	16b. Kind of E	Business/Industry
2	ithin	n Ple	Elementary/Secondary (0-12) College (1-4or 5+)	(life. DO NOT use retired)		. 1
2	filed withi Hygiene. other than	ပိ	9 HI GRADE	MEAT CUTTE	-R TOUL	-TRY COMPANY
anc	htai H	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surna	me)
Ž	hould d Mei merka	ဥ	THOMAS DAVIZ 19a., Informant's Name/Relationship (Type, Print) 11	The state of the s	4 MONIC	FOMERY
Σ	end 2 sho salth and n 27 is m	1 9	DELOPIS DAVIDESTED	9b. Mailing Address (<i>Street and Number</i> or <i>Rura</i>	11:10	/
ē,	s 1 end f Health tem 27 other tr		20a. Method of Disposition 20b. Place	of Disposition (Name of		- City or Town, State
E 0	Pages nent of I int: if Ite iry or o		PLSSurial 2 Li Cremation 3 Li Hemoval from State	tery, crematory or other place)		
altimore,	pemit. Page Depertment of Important: if any injury or once.		21. Signature of Funeral Service Licensee	22. Nama and Address of Facility	(RO) J. T.	P FULCON HOME
ä	Depe Impo any is	G: si	Vi This bally Tolliam	1 JOSERHELT	OROW CAN	TO, MO 21217
			23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac o		Approximate
May prof	Physician		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
-	/Medical		Immediate Cause (Final disease or condition a. End Struster seuting in death) a. End Struster	e Renal Discuse		
	Examiner			e Leval Disese a consequence of):		Unkram
	Si ad	luei	- h			
	certificete be executed ding physician end se es the buriel-transit	Examiner	Sequentially list conditions, day, leading to immediate	a consequence of).		
68760,	be eg	ᄪ	Cause. Enter Underlying Cause (Disease or injury			
587	phys s the	edical	that initiated events resulting in death) Last Due to (or as a	a consequence of):		
×	n certif anding use e	₹	d			
8	death o	Physician	Part II. Other significant conditions contributing to death but not resulting	in the underlying source sizes in Day 1	OOK Didashassassassas	
P.O.	by the	hys				ontribute to the cause of death? 3 Probably
S,	s tha	by P	Seizure Disarde		70.00	O Troubly Y Spinkiowi
ğ	The law requires that the death of the has been signed by the etten page 2 should be deteched for u	2	Corchroyeswic Accident	_	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to
ပ္ပ	aw re as be 2 sh	Be	Concorosco Heciaco		ponomica.	completion of cause of death?
<u> </u>	The ate h	Completed			1 ☐ Yes 2X No	1 ☐ Yes 2 ☐ No
Division of Vital Records,	sicien: The law s certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	26. Place of Death		
0	Physic this c	2	1	Dutpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Ott	
<u>د</u>	Jing P. After fune	달	1 Natural 5 □ Pending (Month, Day Year)	Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occur	red
Ī	deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Placa of Injury - At home		28f. Location (Street and Num)	ber or Rural Route Number.
Š	of or of or	Certification:	4 ☐ Homicide building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, State)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attending Physicien: with 24 hours eiter death: To the Funeral Director: After this certifica completely filled in by the funeral director,	edicai C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination a	ge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurre	and due to the cause(s) and made at the time, date and place,	anner as steted. and due to the cause(s)
	ithin ithe	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		ed (Month, Day, Year)
	F3F8	1		D005(05)	6 (0)	
,	1//		30. Name and address of person who completed cause of death (Item 23a		6101	20
L	X				CA TRILL	NO 21217
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sonature	He fraile	00 130 111 15	
	Registr	ar .	JUN I 5 24 Julian	J De Popular		

			1 - For State Registrar		State o	f Marylar		artment of F			_	giene Reg. No.	211115	19899
ı	Physic	an	Decedent's Name (First,		st)						2. Date of De. Month	Day	/ Year	3. Time of Death
	/Medi	cal		1yn			Decker				June 8	-	05	10:20 P.™
	Examir	ner	4a. Facility Name (If not ins Vindobona					4b. City, Town, o Braddock				4c.	Frederi	
	Funeral		5. Social Security Number	6. Se		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under:	24 Hrs.	8. Date of Birt	h		place (State or Foreign
	Director		214-10-1613 Usual Residence of Deced		□M XXF	88	Yrs.	Months Days	Hours	Min.	April	17,	A COU	aryland
	/land		10a. State 10b. C	ounty		10c. Cit	ty, Town or Lo							10d. Inside City Limits
	Ba-feh	Director	Maryland		derick		_	Freder:	ick					¥ Yes 2 No
	th with th	al Dire	10e. Street and Number 300 Park	Avenu	е			10f. Zip Code	2170	01		10g. Citi	zen of What Cou U.S.	ntry? A•
980	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow sideal Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ☒ Widowed 4 □ Div		12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	2 X No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Orig an, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ameri Black, White, Specify: Whit	etc.
21215-0036	72 hor natura	Completed	15. De	cedent's Ed	ucation de completed)		16a. Dece	dent's Usual Occup	ation	t of workin	ng	16b. Ki	nd of Business/In	
121		mple	Elementary/Secondary (College (1	-4or 5+)		kind of work done DO NOT use retired		O WOIKII	ig	_		
2	e filed within Il Hygiene. other than " vent, I'le Me		17. Father's Name (First, M	liddle. Last)	-		кеат	Es t ate B		r's Namo	(First, Middle,	_	al Estat	e
Maryland	2 should be to and Mental by is marked of reumatic ever	To Be	Roy Jac		fauver				18. Motife		iet Ru		,	
Mar	and 2 sho eaith and n 27 is m		19a. Informant's Name/Rel Anna Lee Ho					ng Address <i>(Street a</i>						Code)
Baltimore,	of Ho		20a. Method of Disposition 1 ☐XBurial 2 ☐ Crem	ation 3 🗆	Removal from	_ 0	Place of Dispo	sition (Name of	ca)	D	ate	20c. Lo	cation - City or To	
Him	Pa In Figure		'4 Donation 5 Dot 21. Sign ware of Funeral Sc	her (Specify)	St.	-	Cemetery	1					Maryland
Ba	permit. Departr Importe any inje		23a. Part1. Enter the disea	C.	C-120	I fee MOD		Name and Address Keeney & 106 East	t Chur	ch S	treet.	Free	Home derick.	Maryland
8760,	death certificate be executed Wedical Washington and A for use as the burial-transit	edical Examiner	shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Eather Underlying Cause (Disease or injury that intitated events resulting in death) Last	i. List only o	aDue to (or as a consequence or a consequence or a consequence or a consequence or a consequenc	uence of):) plese	rel					Interval Between Onset and Death
.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 No 9 □ Unknown	arit.		rth 2∏Feta ant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				2	3d. Date of delive Month	ery Day Year
rds, P	w requires that been signed be should be det	by	Part II. Other significant co	onditions co	ontributing to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	1		ne cause of death?
Vital Records	The la ate has page 2	e Completed	25. Was case referred to m	adical							24a. Was a autop: perfor 1 Yes	SV	24b. Were auto prior to condeath?	psy findings available mpletion of cause of
<u> </u>	di S	To B	examiner?	-	Hospital:	npatient 2	ER/Outpatien	t 3□ DOA Othe		-	(Check only di	ence 6	□Other (Specify	ν)
n of			27. Manner of Peath 1 Natural 5 ☐ F	ending	28a. Date o		28b. Time of Injury	28c. Injury Work	at/		8d. Describe h			,
sio	Attending r death. sctor: After by the fune	catl	2 Accident	vestigation could not be				M 1 🗆 `	Yes 2□N					
Division	el or At s after o l Direct d in by	Certification:	4 Homicide	etermined	289. Place	of Injury - At ho ig, etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory, office		2	8f. Location (S City or Tow	treet and n, State)	l Number or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: Scompletely filled in by the	edical C	29a. Certifier 1X Ce (Check only one)	rtifying Phy dical Exam	vsician: To the iner: On the ba and mann	sis of examina	wledge, death tion and/or in	occurred at the timestigation, in my op	ne, date and pinion, death	place, a	nd due to the c d at the time, d	ause(s) a ate and	and manner as st place, and due to	ated. the cause(s)
	To the To the Coomp	*	29b. Signature and title of c	ertifier	2/	P		29c. License			2	9d. Date	signed (Month,	Day, Year)
i	0		* X My	X-1	1 ans	nen	\sim	•	1397	7/		6/10	105	
_	U			Kaufma	ann M.I	0., 300	West	Print) Ninth Str	eet,	Fred	erick,	MD 2	21701	
	Sta Registr	_	31. Date filed (Month, Day,	15 20	105 322 Ac	egistrar's Signa	To Apo	ode)						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Item 5 per flh e849 11-14-05 vt. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Wright Fields Jr. 3:30 PM 13, 2005 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richie House Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, 5. Social Socrity Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**⊠**M 2□F 65 242-04-1191 Yrs Director April 18,1940 Lunberton, NC. Usual Residence of Decedent with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Director MD. Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Mc Guirk Drive 21060 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or itam any injury or other traumatic event, the Medical Exemples. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: American Indian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Drywaller Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Wright Fields Mina Mae Haggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Mc Guirk Drive, Glen Burnie, MD. 21060 Mattie J. Fields wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 16, 20c. Location - City or Town, State 11 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2005 Dundalk, MD. 22. Name and Address of Facility
Connelly Funeral Home Of Dundlak, P.A.
7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service Licenses thou 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician a metastatic months lung cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No this certificate has 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospice 1 ☐ Yes 2 ☑ No 2 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100 MD D24170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NENTANST Bulfinore MD 21201 Richa 838 ISC MID Hospice 31. Date filed (Month, Day, Year) 32, Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

JUN 1 5 2005

Wright Fields

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

				Otato of Mic	zi yidild / L	Certific		Death	vieritai i iy	Reg. No.	05	1990	
	Dhusia		1. Decedent's Name (First, Middle, Las	t)					2. Date of De		V	3. Time of Dea	ıth
J	Physic /Medi		CECILE HARRINGT	ON FOSTE	R				Ture	li 2	005	9-05AT	7
2	Examir		4a. Fecility Name (If not institution, give	street and number)				4b. City, Town, or I	Location of Deat	h 4c. Count	y of Death		
1			830 W. 40th. Str	eet				Baltim	ore	N	/A		
	Funeral Director		210 00 3709	ox 7. Age □M 2X0 F	95 (In yrs. last bir	Yrs. If Un Mont	nder 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept. 1	iy, Yeer) .0, 1909	9. Birthp Cour Uta	place (State or For ntry) Ah	reign
	end w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					1.	10d. Inside City Lir	mite
	Maryl f sho	ō	Maryland N/A			imore						1 🕅 Yes 2 🗆	
	1 the	Directo	10e. Street and Number		Dart		Zip Code			10g. Citizen of	What Cou	ntry?	
	ter death with the Marylen Items 23a or 28a-f show Inst. must be notitied at		830 W. 40th. Str	*eet				21211		-	5.A.		
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U,S.	13. Was De	ecedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		ce - Americ		
Baltimore, Maryland 21215-0020	in 72 hours after death with the Marylend o "natural", or Items 23a or 28a-f show Nedfool Examiner must be notitied at	δ	1 ☐ Never Married 2 ☐ Married 3 ☐ X Widowed 4 ☐ Divorced	1 Yes 2 YN If Yes, Give Year or Dates:	lo	i	s 25 No	Specify:	o Hican, etc.)		ack, White, ^{fy:} Whi		
5	72 h 'natu	etec	15. Decedent's Edu (Specify only highest gred	icetion le completed)	16a.	Decedent's U	Isual Occup	pation during most of wor	kina	16b. Kind of E	Jusiness/In	dustry	
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-				during most of word d)		Own 1	Homo		
7	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	5+ years	5	Ноп	nemake	18. Mother's Nan	no /Eirot Middlo				
aŭ	d be feet of section	Be C		ww.inatan							,		
7	should be ind Mental i marked c	ို	19a. Informant's Name/Relationship (T	rrington	19b	Mailing Addr	ess (Street	Laurett		Ander		Code)	
Š	nd 2 : lith er 27 is r trau		Carolyn F. Meredi			-		rdens Ro				· ·	12
ē,	ges 1 and 2 should be filed within to f Health end Mental Hygiene. If item 27 is marked other than or other traumatic avant, the M.		20a. Method of Disposition		20b. Place of cemeter	Disposition (/	Name of	on)	Date	20c. Location	- City or To	land 212	12
Ē	Pages nent of I ant: if Ite		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			Mount		1	6-14-05	Raltin	nore	Maryland	Ь
aĦ	보본런근		21. Signature of Funeral Service Licens		020011	22 Name	and Addre	es of Facility					<u>u</u>
~	permi Depa impo any ir		Leone I. Fe	vun		6500	ell-W York	Viedefeld Road B	Funeral altimore	Home, e, Maryl	Inc. Land		
	Dharaistan		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ne cause on each lin	the death. Do r e.	ot enter the m	node of dyir	ng, such es cardiac	or respiratory e	rrest,	a 1	Approximate Interval Between Onset end Death	1
Ì	Physician /Medical		Immediate Ceuse (Final	11	•	0. 10.		0 1:	0	Α .		V	
	Examiner		disease or condition resulting in death)					leropie	heart	diseas	2	Tears	
		Jer		e i	Due to (or es e d	onsequence (or):				Total most:		
	The law requires thet the deeth certificate be executed ste hes been signed by the attending physician and page 2 should be deteched for use as the buriel-transit	edical Examiner	Sequentially list conditions,)	Due to (or as e o	onsequence o	of):				- !		
Ö,	e exe lan a uniel⊣	ĕ	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury								į		
68760,	ate b	dica	that minated events resulting in death) Last). C	Due to (or as a c	onsequence o	of):						
9 x	entific ding p	2	L.	4									
8	eth c	lan											
o	he de ched	Physician/	Part II. Other significant conditions con	tributing to death but	t not resulting in	the underlyin	g cause giv	en in Part I.	23b. Did 1	obscco use co	ntribute to	the cause of dea	ath?
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S	luires n sigr	by Dy							24a. Wes	en eutopsy	24b. We	ere autopsy finding	gs
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Division of Vital Records, P.O. Box	Attending Physicien: or death. ector: After this certific by the funeral director.	ation:	27. Manfier of Death 1 ANatural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day			28c. Injur		28d. Describe		. , ,	,	
Divis	i or Atter efter des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, far (Specify)	m, street, fact	ory, office		28f. Location (S City or Tow		er or Rure	l Route Number,	
	To the Hospital or Attending Physicien: The I within 24 hours effer death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one) 1 CertifyIng Phys	siclan: To the best of ner: On the basis of e end menner state	examination and	death occurre or investigation	ed at the tin	ne, date and place, pinion, death occur	and due to the o	cause(s) and madate and place,	anner as st and due to	ated. the ceuse(s)	
	Fo the vithin Fo the complex c	Me	29b. Signature and title of certifier			2	29c. Licens	e number		29d. Date signe	d (Month, I	Dey, Yeer)	
			M Trabelon Ma	e grea	Ar Or IA		D136	57		June 1	3.20	125	
,	01	ŀ	30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	Type Print)							
	A,		7. BABELLE The S 31. Date filed (Month, Day, Year)	REGOR,	830W	40%	th STR	LEGT, BA	LJIDIA	E, MJ	212	_11	
	Sta Registra		JUN 1 5 200	5 House	, John /	porte	,						

Box 68760. P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Year Melvin Ernest Flynn June 3:30 p м 6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4322 Keeners Rd Chase MD Baltimore 5. Social Security Number 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3-10-30 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 218-26-1407 75Yrs. Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If item 27 le marked other then "naturel", or Items 23a or 28a-1 show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ust be notified at 1 Yes 2 No Completed by Funeral Director MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4322 Keeners Rd 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ Yolo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other treumatic event, the Medical Example et a 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 7th College (1-4or 5+) Mechanic Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George C. Flynn Melva M. Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Flynn 2411 Ellis Rd. Balto. MD 21234 20a. Method of Disposition

1 Burial 2 Acremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö permit. Page Department of Importent: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 6-9-05 Dundalk, MD 22. Name and Address of FacilityWesley Chavis Jr. FH 21. Signature of Funeral Service Licensee 7 2007 Eastern Ave. Balto. MD 21231 anel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 Probably 4 Unknown 1 🗌 Yes director, page 2 should Be Completed 24a. Was an autopsy performed 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 4 Nursing Home Residence 6 Other (Specify)
28d. Sescribe how injury occurred Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hou. The Funerel F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and matter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D39758 stress of person who completed cause of death (Item 23a) (Type, Print) SCHENCE IMD 9101 Franklin SQ-Dr. Suite 321, "BAUTO, MD, 21237

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Coule

egistrar's Signatut

			State of Manyland / Department of Health and	•	_	
			State of Maryland / Department of Health and Certificate of Death		200	5 10000
	_		1. Decedent's Name (First, Middle, Last)	2. Date of Death	. No. 1 0 0	3. Time of Death
	Physici		Vernon Fitzgerald	Month q	Day Year	
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Dea	
	Examin	CI	MANOR CARE WOODBRIDGE VALLEY N.H. CATONSVIL	IF.	0	TIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day, Yo		rthplace (State or Foreign ountry)
	Director		212-30-1815 13 Yrs.	JAN. 28	1932 M	ARYLAND
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	/		10d. Inside City Limits
	daryli f sho	or	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			1 XYes 2 □ No
	the A	rect	MARYLAND BALTIMORE (000 LA) 100. Street and Number 101. Zip Code		. Citizen of What C	ountry?
	23a or	i D	2137 ST 111KES / ANE 2126	7	/15	Δ
	death with the Maryland oms 23e or 28e-f show	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (See Specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Am	
စ္	after or ite	Fui	Armed Forces? Mover Married Armed Forces If Yes, specify Cuban, Mexican, Puerion 1 Never Married 1 Never Marr	o Hican, etc.)	Black, Whi	ite, etc.
5-0036	72 hours after "natural", or ite		3 Wildowed 4 Divorced Year or Dates:		Specify: B	LACK
5	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking 16	b. Kind of Business	s/Industry
2121	ed within /giene. ier than "	duc	Elementary/Secondary (0-12) College (1-4or 5+) FROFESSOR MATH STATE College (1-4or 5+)	TO CONT HO	NITH COOL	ENLANC NO ADM
	Hilled Hygi other ent,	Be C		ne (First, Middle, Mai		INANCING HUPI
lan	ould be Mental arked c	To B	WALTER J. FITZGERALD QUEE	NIE	V.	GROSS
Maryland	and N is ma	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		ity or Town, State,	
ED.	iges 1 and 2 should be filed within 72 hours after death with the Manylan it of Health and Mental Hygiene. If item 27 is marked other than. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event. It is Manical Examiling must be radified at		BRANDON FITZGERALD (SON) 685 CONCERTO LANE,	SIL VERSF	PRING ML	7 Town, State
ore	of H If iter		20a. Method of Disposition 1 ※ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location City or	Town, State
Baltimore	tant:		'4 Donation 5 Other (Specify) GARRISON FOREST 106-	15-05 0	WINGS M	ILLS MD.
Bal	permit. Pages Department of Important: If i any njury or o		21. Signarding of Fun ral Service Prensee 22. Name and Address of Facility:	BROWN	JR. FUN	ERAL HOME
	40 40	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	N AVE. A	SALTO.	
J.	ui		snock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Finer Underlying.			/
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ord	w require been si should I	ted	Mixed Dementiq	1 ☐ Yes	2 M No 3□P	robably 4 Unknown
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<u>=</u>	ding Physician: The h. After this certificate hi funeral director, page	Con		performed 1 ☐ Yes 2 🗷	l? death? No 1 ☐ Yes	
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O	rs after al Dire	Certification:	a building, etc. (Specify)	City or Town, S	tate)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only Check on Che	, and due to the caus	e(s) and manner a	s stated.
	the the the the the the the the the the	Medical	and manner stated.			
	A L	_		į.	Date signed (Mon	
6			41M. Alolto, ND D3332		01176	2005
	1/		30. Name and address of person who completed cause of death (Item 23a) (Type Print)			
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 Business Center Dr. Reisters town	MD	21136	
	Sta	te		MD	21126	

		,	1 - For State Registrar	State of N	Maryland / [epartm <i>Certific</i>				-	giene	005	19904
	Physic		1. Decedent's Name (First, Middle, La Gladys Jean	*						2. Date of De Month June		2005	3. Time of Death 12:35 p M
	/Medi Examir		4a. Facility Name (If not institution, given 2017 Hanover Pi	e street and numbe	er)	4b. 0	City, Town, or Hamps		of Death	00110		ounty of Deat	h
	Funeral Director		2.0 /2 00/1	Sex 7. 1□M 2☐F	Age (In yrs. last birt	hday) If Un Mon	hs Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 2	th y, Year) 3, 1931	9. Birti Co Lai	hplace (State or Foreign untry) cyland
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Carro	11	10c. City, Town	or Location	Proposal			A			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28	i Dire	10e. Street and Number 2017 Hanover Pike	9		10f	Zip Code	1			10g. Citize	u.S.A.	•
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, I're Medical Examinar must be restlined at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ቯ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date:	a? Ino			spanic Ori n, Mexicar		ecify Yes or No Rican, etc.)		. Race - Ame Black, White	rican Indian,
Maryland 21215-0036	e filed within 72 ho al Hygiene. other then "natur vent, It's Medicall	Completed	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)	ducation ade completed) College (1-4c	vr. 5.4.)	Decedent's l (Give kind of life. DO NO ecreta	work done of T use retired	ation furing mos	t of workir	ng		of Business/I	unty ducation
yland	0 = 0 \$	To Be C	17. Father's Name (First, Middle, Last Lawrence Lester							(First, Middle)		•	
Mar	nd 2 sho alth and 27 le ma ir treume		19a. Informant's Name/Relationship (Laura Foster Kreb							Route Numb			ip Code)
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Balt	permit. Departr Importe any inju		21. Signature of Funeral Service Lice	nsee		122 Name 13296	and Address rdt Fr Charm	s of Facilit inera il Dr	I Cha	apel P	Δ	. 2110	•
	rate be executed hysician and hysician and the buriat-fransit the buri	l Examiner	23a. Pañ1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a c.	as a consequence of a c	nal i			cardiac o	r respiratory ai	rrest,		Approximate Interval Between Onset and Death WROKS
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)	To To Com	×	29b. Signature and title operation	enda	. Ki		29c. License	number	,		29d. Date s	igned (Month,	Day, Year)
V			30. Name and address of person who	completed cause of	death (Item 23a) (T	Type, Print)	D. M.	121	074			1	-
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 5 2	32. Posis	death (Item 23a) (1 d, Han trar's Signature	Spare	w						

		1	1- For State of Maryland / Dep	eartment of Health and Mertificate of Death		ne No.2005 19905
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		HELEN MYRA GERNHART GREGG		June 13	, 2005 1:25 P M
7	Examin	er.	4a. Facility Name (If not institution, give street and number) 331 Dumbarton Road	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Baltimore County 9. Birthplace (State or Foreign Country)
	Director		212-18-0499 1 M 27 F 87 Yrs.	Months Days Hours Min.	Mar 23, 1	**
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	Tal. 25, 1	10d. Inside City Limits
	Maryli f sho	ō	Maryland Baltimore County Rodger			1 ☐ Yes 2 X No
	or 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show offed Examinet must be nyilled at		331 Dumbarton Road	21212		USA
	er dez Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
336	urs aft	by F	1 Never Married 2 Married 1	1 ☐ Yes 2 X No Specify:		Specify: White
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Baltimore, Maryland 21215-0036	should be nd Mental marked o	To B	George Gernhart		anor Louis	
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ooa	law as b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R	The ate h page	Con			performed	?/ death?
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ion	Attending F r death. sctor: After by the funera	atio	1 Satural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division		Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
Ω	lospital of hours af uneral D		200 Codifice of Codificing Physician Turbs by Art 1			
	T 4 IT A	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	n occurred at the time, date and place, ivestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
a) j	To the within 2 To the complet	N	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month Day, Year)
	1/1		Jean July	D CC0	4 > 4	0/14/05
4) (505 OSCER DR.S	VITE 306	Towson MD. 21204
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	•	For State Registrar	State	or mary	land / De _l <i>Ce</i>	e <i>rtificate</i>				ientai i i	yyıeı Reg.		C	1991
		1. Decedent's Name (First, Middle, L	.ast)		-					2. Date of D		Day \	Year	3. Time of De
Physicia /Medic		Helen Edna G	ier							June		2005	i o ai	8:45 A
Examin		4a. Facility Name (If not institution, g	ive street and n	umber)		4b. City,	Town, or	Location of	of Death			4c. County of	Death	
		3728 Blenheim	Road				oen:	ix				Bal [.]	timo	re
uneral		Social Security Number 6.	Sex 1 □ M 2 🖾 F	7. Age (In	yrs. last birthda	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I	Birth Day, Ye	ar)	9. Birthpl	ace (State or Fi
irector		214-01-6939	I □ M 2 X P		94 Yrs.					March	10,	1911	ME	
* 100		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or	Location		-					10	Dd. tnside City L
sho	_	Toa. State		100										1 Tes 2
8a-1	Director	MD Baltimo	re		Phoeni		-				10-	Older of Mile		
or 2	ä	10e. Street and Number				10f. Zip					log.	Citizen of Wh	iat Coun	try ?
3 23e	Ta .	3728 Blenheim R				211			1 0 /0			USA	A /	- 1 - 1
"natural", or items 23a or 28a-i show edical Exercit at mast be multified at	Funeral	11. Marital Status	Armed I		In U.S. 1	 Was Deceded If Yes, specified 	ent of H	an, Mexicar	gin? (Spen, Puerto	Rican, etc.)	NO-	14. Race Black,	White,	
0	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	If Yes, C	2 X No Sive		1 ☐ Yes	No XIS	Specify:				Specify:		White
lura E E		15. Decedent's	1 23.5	Dates.	16a De	edent's Usua	I Occup	ation	_		166	. Kind of Busi	inass/Inc	lustry
"na	Completed	(Specify only highest g	rade completed		(Gi	ve kind of wor . DO NOT us	rk done d	during mos	t of work	ing	100	Garmer		lustry
than be M	m'	Elementary/Secondary (0-12)	College	(1-4or 5+)		Bookeep						Manufa		ina
d other than "natus event, the Medical		17. Father's Name (First, Middle, La.	st)					18. Mothe	er's Name	(First, Midd		den Sumame,		T118
o pe	Be C	John W. Ad	dams					Εv	a K	Gutma	n			
mari	۵	19a. Informant's Name/Relationship			19b. Ma	ilina Address	(Street a					ty or Town, S	tate. Zip	Code)
If item 27 ia marked other than "I or other traumatic event, the Med		Robert F. Hare		-law		8 Bler						•	131	,
em other		20a. Method of Disposition			0b. Place of Dis	position (Nan	ne of	1		Date	-	. Location - C	ity or To	wn, State
ant: If ite ury or of		1 Burial 2 □ Cremation 3		m State		rematory or o	,		n <i>c /</i> 1	3/2005		Baltimo		MD
Important: It any injury o once.		* 4 Donation 5 Other (Special Signature of Funeral Service Lie		L	Oruid Ri	22. Name an					-			
any i		21. Signatury of Purioral Service Co	/	Cos ter					10				raı	Home, I
		23a. Part1. En er the disease, or co				1050 \						21 204		Approximate
sician		shock, or heart failure. List on Immediate Cause (Final	ly one cause or	each line.	er Cano		, -,	3,		,				Onset and Dea
edical		disease or condition resulting in death)	aDue t		nsequence of):	,61								
niner				Lur	ng Cance	er – Me	etasi	tatic						
	Je.	Sequentially list conditions, if any, leading to immediate	Due t	o (or as a co	nsequence of):									
ransi	Examiner	Cause (Disease or injury that initiated events	С.											_
an ar rial-t		resulting in death) Last	Due t	o (or as a co	nsequence of):									
physician and the burial-transit	dicai		d											
as th	Ned	IF FEMALE:												
attending for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, o	outcome of pr	regnancy Fetal death	3 □Ectopic pr	egnancy	,				23d. Date Mont		ry Day Yea
the at	sici	in the past 12 months? 1 Yes 2 No	4 □ Pre 9 □ Uni	gnant at time	of death	5 Other (sp	ecify)					IVIOIT	,11	Day 10a
tac	hy	9 Unknown												
90	by	Part II. Other significant conditions	s contributing to	death but no	ot resulting in the	underlying c	ause giv	en in Parti						e cause of deat
should	ted									1	_ res	2 □ No 3	Prob	ably 4 ∏Unk
2 5	Completed									24a. Wa	lopsy	l pri	ior to con	osy findings ava
as t	no:									pe 1 ☐ Yes	formed 2 V		ath?] Yes	2□ No
ate has t	9	25. Was case referred to medical						26. Place	of Deatl	n (Check onl	/ one)			
rtificate has to	m	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 [Inpatient	2 ER/Outpat	ient 3 DC	Oth Oth	er: 4 🗆 Nu	ursing Ho	me 5 XX e	sidence	e 6 □Other	(Specify	<i>'</i>)
is certificate has director, page 2	0 8		28a. Dai	te of Injury onth, Day Ye	ar) 28b. Time tnjur	of 2	8c. Injun Wor	y at k?		28d. Describ	e how i	njury occurre	d	
is certificate nas director, page 2	To B	27. Manner of Death				М		Yes 2	No					
Arter this certificate has funeral director, page 2	To B	1 XNatural 5 ☐ Pending investigat			At home, farm, pecify)	street, factory	, office			28f. Location City or 7			r or Rura	l Route Number
or: Atter this certificate has ne funeral director, page 2	To B	1 XNatural 5 Pending	the l	.ce of Intury - Iding, etc. (S	pourly)									
or: Alter this certificate has ne funeral director, page 2	To B	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not determine	the l	Iding, etc. (S	pacity)				11					
or: After this certificate has ne funeral director, page 2	Certification: To B	1 ⊠Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 1 □ Certifier 1 □ Certifying	28e. Pta bui	the best of m	y knowledge, de	eath occurred	at the tin							
or: Atter this certificate has ne funeral director, page 2	Certification: To B	1 Natural 5 Pending investigat 3 Suicide 4 Homicide 29a. Certifier (check only one) 1 Certifying 2 Medicel Ex	28e. Pla bui Physicien: To t caminer: On the	the best of m	y knowledge, de	eath occurred investigation	at the tin	pinion, dea			e, date	and place, an	nd due to	the cause(s)
or: Atter this certificate has ne funeral director, page 2	To B	1 ⊠Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 29a. Certifier (Check only) 1 ☑ Certifying 2 □ Medicel Ex	28e. Pla bui Physicien: To t caminer: On the	he best of my	y knowledge, de	eath occurred investigation	at the tin , in my o	pinion, dea	ath occur	red at the tim	e, date 29d.	and place, an	(Month, I	the cause(s) Day, Year)
pr: Alter this certificate has ne funeral director, page 2	Certification: To B	1 Natural 5 Pending investigat 3 Suicide 4 Homicide 29a. Certifier (check only one) 1 Certifying 2 Medicel Ex	28e. Pla bui Physicien: To t caminer: On the	he best of my	y knowledge, de	eath occurred investigation	at the tin , in my o	pinion, dea	ath occur	red at the tim	e, date 29d.	and place, an	(Month, I	the cause(s) Day, Year)
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			1 - State Registrar		Reg. No.2 () () 5 9907
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Marta Goycoolea 4a. Facility Name (If not institution, give street and number)	2. Date of Dea Month June 10 4b. City, Town, or Location of Death	Day Year
	Funeral Director	ier	Montgomery Hospice Casey House 5. Social Security Number 216-64-7064 Montgomery Hospice Casey House 6. Sax 1 M 2 M F 68 Yrs.	Rockville	Montgomery 9. Birthplace (State or Foreign Country)
036	72 hours after death with the Maryland neturel; or Hems 23e or 28a-f ehow after the factor of the fa	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Montgomery Rockvil 10e. Street and Number 118 Monroe Street, #107 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Pass 2 No If Yes, Give 19 Year or Dates:	Location 1e 10f. Zip Code	10d. Inside City Limits 1 ☑ Yes 2 □ No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	be filed within tal Hygiene. d other than "	Be Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) DOKKeeper 18. Mother's Name (First, Middle, A	16b. Kind of Business/Industry Accounting
Baltimore, Maryla	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked o any injury or other traumatic eve once.	To	Jose Ortuzar / Son 120 20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	Heaven June 16,	, City or Town, State, Zip Code) , Maryland 20851 20c. Location - City or Town, State Silver Spring MD
8760,	death certificate be executed with the second of a continuation of the second of the s	dlcal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	lockville, Maryland 20850-	-2805
O. Box 6	death certiff e attending id for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
s, D	aw requires s been sign 2 should be	Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the	1 □ Ye 24a. Was ai	
Division of Vital Record	Physicien: r this certifica ral director, I	Certification; To Be Com	25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death Check only one ont 3 DOA Other: 4 Nursing Home 5 Reside of 28c. Injury at Work? M 1 Yes 2 No	prior to completion of cause of death? No 1 Yes 2 No e) Ince 6 Other (Specify) Hospice w injury occurred
Z	To the Hospitel or Attending within 24 hours after death. To the Funerel Diractor: After completely filled in by the fune	edical Certific	4 Homicide determined 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	City or Town	uisa(s) and manner as stated
ſ	To the within 2 To the Comple	Med	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number 25	Od. Date signed (Mopth, Day, Year)
1	Sta Registr		Charles Harrison, M.D. 6001 Munca: 31. Date filed (Month, Day, Year) 32. Registra's Signature JUN 15 2005	ster Mill Road, Rockville,	Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Name (If not institution, give street and number 4b, City, Town, or Location of Death Examiner 4c. County of Death 31 If Under Date of Birth (Month, Pay, 6. Sex . Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 1 M 2 Yrs. Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits To Be Completed by Funeral Director 1 res 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married ŏ Yes, Give ear or Dates: 1 ☐ Yes 2 📉 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then." dary (0-12) College (1-4or 5+) cutive (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 1 to MD 21214 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) njury or 21. Signature of Funeral Service Licensee acka. Part1. It is the disease, or complifations that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER NONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: ပ 1 ☐ Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ★ ther (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel C 29a. Certifier ⊁Ercertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58302 74NC 14 2005

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

N. Charles

SH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAAAN CHHT2L 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No., . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year William Delphey Handley /Medical June 4. 2005 10:34 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Nursing Home Frederick Frederick Brunder 24 Hrs. Months Days Hours Min. (Month, Day, Year) Frederick 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠** M 2□ F Director 78 219-20-2015 13, 1926 Maryland Aug. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Directo 1X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a 203 Meadowdale Lane death 21702 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Electric/ Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor/Customer Service Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William J. Handley Lettie Delphey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Mary Anna Handley, wife 203 Meadowdale Lane, Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery |6/8/2005 Frederick, Maryland 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Uneral Service License 115er M00999 106 East Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Pneumonia 1 month resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-t Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Diabetes, Dementia page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To Cther: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11120 e 4 Fre D09689 June 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, MD, 300 West Ninth Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) JUN 1 5 2005 Registrar

			For State Registrar	State of Mar		artment of H	lealth and I			0.05	19910
			Registrar 1. Decedent's Name (First, Middle, L	aet)	<u></u>	rtificate of	Dealli	2. Date of De.	Reg. No.		3. Time of Death
	Physici							Month	Day	Year	
	/Medic Examin		Thomas E. Harge 4a. Fecility Name (If not institution, gi	ST, Sr.		4b. City. Town. o	r Location of Death	<u> </u>	14 4c. Cou	2005 inty of Death	5:25 AM
	Examin	E	Gilchrist Nursi			Towson				ltimore	
	Funeral			Sex 7. Age (i	In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	th		elace (State or Foreign atry)
ı	Director		215-30-3996	1 X M 2□F	72 Yrs.	Months Days	Hours Min.	05/10/			vland
	and w		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation				1	0d. Inside City Limits
	Maryli f eho	ō									1 ☐ Yes 2 🛣 No
	the 1	Director	MD Harfo	ra	Fallsto	10f. Zip Code			10a. Citizen	of What Cour	nto?
	3e or		1130 Sturbridge	Road		21047	1				
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	Was Decedent of H		pecify Yes or No	U.S.	Race - Americ	
9	after or ite	F	1 ☐ Never Married 2X Married	1 ☐ Yes 2 XNo		1 ☐ Yes 2 🛣 No	Specify:	o nican, etc.)		Black, White,	etc.
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						whi	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural; or flems 23e or 28e-f ehow event, the Medical Examiner must be notified at	Completed	15. Decedent's 8 (Specify only highest g	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wor. √I	king		f Business/Ind	
7	withii iene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		lesperson				_	l Heating
	Hyg other	Be C	17. Father's Name (First, Middle, Las	t)	Da	TESPETSON	18. Mother's Nan		Suppl: Maiden Sun		
lan	should be nd Mental marked o	To B	William Hargest				Clara	Griffin	1		
Maryland	s 1 and 2 should by Health and Menistem 27 le marke other treumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or To	wn, State, Zip	Code)
	and 2 ealth n 27 I		Patricia A. Har		1130	Sturbrid	ge Road -		on, Ma	ryland	21047
altimore,	of Hez of Hez If item or othe		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3	I	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	(8)	Date	20c. Location	on - City or To	wn, State
<u>Ē</u>	Pages Iment of tent: If it jury or o		`4 ☐Donation 5 ☐ Other (Spec	ify)	Moreland	Memorial	Pk. 06/1	8/2005	Balti	more,	Maryland
Rail	perrif. Pages Department of Importent: If i any injury or once	H	21. Signature of Funeral Service Lice	ensee							Home, P.A.
	40200	100	One Board Solve the disease of an	Jassahn		1750 Bela				Maryla	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.	e death. Do not er	iter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical	i	Immediate Cause (Final disease or condition resulting in death)	a. Renal	failur	e					Necta
	Examiner			Due to (or as a c							
	1	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Sepsis Due to (or as a c						- 12	1009
	ufed d ansit	Examlner	cause. Enter Underlying Cause Disease or injury that initiated events								
o Î	an an rial-fr		resulting in death) Last	Due to (or as a c	consequence of):						
3/60,	The law requires that the death certificate be execufed to has been signed by the attending physician and bage 2 should be defached for use as the burial-fransit	ical		_ d							
99	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE:			_					
X Q Q	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [Fetal death 3	□Ectopic pregnancy			23d.	Date of delive Month	Day Year
o.	at the de by the a fached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□ Unknown	ne of death 5	Other (specify)					,
1	that the ed by defact	H.	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use c	ontribute to th	ne cause of death?
ecords,	w requires that been signed b should be defa	d b	metastatic L			ain		1 1	∕es 2□No	3 Prob	ably 4 Unknown
S S	w req	lete						24a. Was	an 24	b. Were auto	psy findings available
r	The law	Completed by						autop		prior to cor death?	inpletion of cause of
VItal		0	25. Was case referred to medical				26. Place of Dea			1 🗆 Yes	2□ No
	S S D	To B	examiner? 1 □ Yes 2 🙀 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing H			Other (Specify	hospic
n or	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time		v at k?	28d. Describe h		curred	
<u>0</u>	Attendia deafh. ctor: A y the fu	catl	2 Accident investigation			M 1 1	Yes 2 □ No				
DIVISION	or Attending ifter death. Director: After in by the fune	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, s 'Specify)	reet, factory, office		28f. Location (S City or Tow		mber or Rura	I Route Number,
	pitel ours a erel [29a. Certifier 1 Certifying P	hyeicien: To the heat of a	ny knowladao da-	th occurred at the ti-	no date and size:	and due to the	20100/-> :		atad
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	hysicien: To the best of n miner: On the basis of ex and manner stated	camination and/or is	nvestigation, in my o	pinion, death occur	rred at the time,	date and plac	manner as st e, and due to	the cause(s)
	To the within Fo the complex	SMe	9b. Signature and title of certifier			29c. Licens			29d. Date sig	ned (Month,	Day, Year)
	1		▶ (Alrente	\sim		D 57	3303		JUNE	1420	05
•	0		30. Name and address of person who				-				
1			THE COLUMN	~ 6601 in	charles 1	+ rowan	(ND 2	1204			
	Sta		31. Date filed (Month Den Year) 5	2005 32. registrar's	Signature	town					
	Registr	ar		Men	- ~ //	and the					

		1 - For State Registrar	State of I	Marylar		artmen rtificate			ind M		giene Reg. No.	200	5 19	991
Physicia /Medic		Decedent's Name (First, Middle, KAZELL	Last)				H	ARRI	S	2. Date of Dea Month JUNE	Day	Year 2005	3. Time of	-
Examin		4e. Facility Name (If not institution, THE JOHDS HOPKI 5. Social Security Number	ATIGZOH 29	L	last birthday)		MIH	Location of	CITY	8. Date of Birt		County of Death		
Funeral Director		217-38-3195 Usual Residence of Decedent	1 □ M 2 🔼 F	7		Months	Days	Hours	Min.	(Month, Dat	y, Year) 5, 1933	Col	nplace (State of untry) NC.	si roreig.
Maryland a-f show	ctor	10a. State 10b. County Maryland	N/A	10c. Ci	ty, Town or Lo	ocation	В	altimore)				10d. Inside C 1 ☐Yes	•
th with the 23a or 28 Ist be no	Funeral Director	10e. Street and Number 1700 North Gay Stre	et			10f. Zip	Code	212	13		10g. Citiz	en of What Col U.S	-	
illed within 72 hours after death with the Maryland Hygiene. Ather than "natural", or items 23a or 28a-f show ent, it a Madical Examinat must be notified at	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? _}f No		Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify:		
iene. r than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-40	or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired,	ntion Juring most nemake		ng	16b. Kin	d of Business/I	ndustry Home	
o d al	To Be C	17. Father's Name (First, Middle, La	McCowan					18. Mothe	r's Name	(First, Middle, Elno		Sumame) Cowan		
s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationshi Anthony Harris Son	o (Type, Print)			•				i Route Numbe ore, Maryla		Town, State, Z 213	ip Code)	
nent of He ant: If item ary or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 3 1 → Donation 5 → Other (Specific Properties)			Place of Dispo cemetery, cred Mt	osition (Name matory or o	ther place			ate 06/13/05	20c. Loc	ation - City or 1 Landsdo		
Department of Pinners of Indiana. If ite any injury or of once.		21. Signature of Funeral Service Li	ES.	top	22	2. Name an E 1:	d Addres step B 300 Ei	s of Facilit rothers utaw Pla	y Funer ace Ba	al Service altimore, M	PA d 2121	7		
ysicia ne bur	lical Examiner	23a. Pert1. Enter the disease, or cashock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. H Due to (or b. Due to (or c.	as a consection as a consectin as a consection as a consection as a consection as a consection	quence of):								Approximal Interval Bet Onset and 6 DAY	Death ✓ ડ
e attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 15 No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 Feta	al death 3	Ectopic pr					23	3d. Date of deliment		Year
sbeen signed b	by	Part II. Other significant condition	_		sulting in the u	, -	•				obacco us	e contribute to	the cause of cobably 4 🗆	
ate has page 2	Completed	AMYLOIDOSI	\$									24b. Were aut prior to c death? 1 \(\text{Yes}	topsy findings ompletion of c	availabl ause of
this certific	Be	25. Was case referred to medical examiner?	Hospital:		2		. Othe			(Check only or				
fter this	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	28a. Date of I (Month,		ER/Outpatier 28b. Time of Injury		8c. Injury Work		2	ne 5 □ Resid 28d. Describe h		Other (Spec	iry)	
io the nospital of Atlanta within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 288. Place of	Injury - At h etc. (Speci	ome, farm, str fy)	eet, factory	, office		2	28f. Location (5 City or Tow		Number or Ru	ral Route Num	iber,
the Hosp lin 24 hou the Funei pletely fil	ledical	(Check only 2 Medical E	Physician: To the be caminer: On the basi and manner	s of examina	owledge, deatl ation and/or in	vestigation,	, in my of	oinion, dea	d place, a th occurre	ed at the time, o	date and p	place, and due	to the cause(s	s)
To T Com	Σ	29b. Signature and title of certifier	~			1	c. License	-000				signed (Month		
Sta		30. Name and address of purson was TAMES KIM, M.D., S 31. Date filed (Month, Day, Year)	OHUZ HOPKIA		ITAL, 60		TH h	DOLFE	STREE	ET, BALTI	MORE	, MARYL	AND 21	287

			. For	State of Maryland			Mental Hygier	ne 200	E 10010
			State Registrar		Certifica	te of Death	Reg. i	No	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Las	" Hebr)			200 ^{Year}	1:45 P M
	/Medic Examin	er	4a. Fecility Name (If not institution, give reater Baltimon	street and number)		, Town, or Location of Death		4c County of Deet Baltim	
6	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	ast birthday) It Under Yrs. Months		8. Date of Birth (Month, Day, Ye	ar) C9	hptece (State or Foreign
	Director		Usuet Residence of Decedent 10a. State 10b. County	10c City	, Town or Location	1 15	06/13/2	2005 M	10d. Inside City Limits
	death with the Maryland ime 23a or 28a-f show r must be notified at	tor	MD	B	altimos	- City			1 ⊠Yes 2 No
	with the	Direc	10e. Street and Number	+20	10f. Z	p Code	10g.	Citizen of What Co	ountry?
	ous after death with the Marylar rat, or Neme 23a or 28a-f ehow Exam at must be molified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No	tf Yes, sp	edent of Hispanic Origin? (Secfly Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
0036	"natural", or He	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes		100	Specify:	hite
215-003	"na	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		life. DO NOT	ork done during most of wor use retired)		. Kind of Business/	industry
2	a filed within 72 if Hygiene. other then "na: ont, if a Medic	Con	17. Father's Name (First, Middle, Last)	0	infa		ne (First, Middle, Maid	den Sumame)	
/au		To Be	James Step	hen Hebl		Amar	ida Rr	rea T	Topper
Maryland	2 sh and is m		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing Addres	is (Street and Number or Ru	ral Route Number, Ci	ty or Town, State, 2	Zip Code) '
	es 1 and of Health of Hem 27 r other to		20a. Method of Disposition	CO	ace of Disposition (Nametery, crematory or	ame of other place).	Date 20c	Location - City or	Town, State
#	permit. Pages Department of I Importent: If It eny injury or o		1 □ Bunal 2 ★ Cremation 3 □ '4 □ Donation 5 □ Other (Specify) OK	EEN MU	TUNE And Address of Facility HE	15,2005 B		E, MD
Ba	Depa Impo eny ii		21. Signature of Funeral Service Licen	NACO	16974		monkton,		1111
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ptications that caused the death one cause on each line.	0		or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediete Cause (Final disease or condition resulting in death)	a. EXTLEME Due to (or as a consequ	lence of):	ATURTY	22 WH	1103	Thr. 15 min
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience of):				
	nd transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
760,	te be executed ysician and ie burial-transit	cal Ex	Tosulary in Godiny East	Due to (or as a consequent	lence ot):				
	ertificat ling phy e as th		IF FEMALE:	00- 4					
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 📆No 9 ☐ Unknown	23c. tf yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic			23d. Date of del Month	Day Year
S, D	uires that signed b d be deta		Part II. Other significant conditions c	ontributing to death but not resu	ilting in the underlying	cause given in Part I.	23e. Did tobec		o the cause of death?
Vital Records,	sw requir s been si 2 should	Completed					24a. Was an	24b. Were at	utopsy findings available comptetion of cause of
E Re	: The lav	Com					autopsy performed	death?	_
	ysicien: Th is certificate director, pag	To Be	25. Was case reterred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3□ [Other	ath <i>(Check</i> on <i>ly one)</i> Iome 5 ☐ Residence	e 6 ☐Other (Spe	ocify)
o uc	Attending Physicien: sr death. ector: After this certifica by the funeral director. I	lon: T	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Division of	l or Attend after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	1			28t. Location (Stree City or Town, S		ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death occurre	d at the time, date and place on, in my opinion, death occu	, and due to the caus irred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the To the Comple	Mec	29b. Signature and title of certifier	G. C. C. C. C. C. C. C. C. C. C. C. C. C.	_	9c. License number	1	Date signed (Mont	
)			Housen De	enparent		D29475	7	UNE 13,	2005
			30. Name and address of person who How AND T. B.	completed cause of death (term	123a) (Type, Print)	C, 6701 Non	H CHANUES !	ST. BALI	UMOLE MD 21204
	Sta Regist		31. Date tiled (Month, Dey, Year) JUN 1 5 200	2. Registrar's Signal		,			

DHMH 17 Rev 1/2001

		1 - For State Registrar			Mental Hygi	ene g. No. 2015 1994
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last, Garnett 4a. Facility Name (If not institution, give 4111 White Aven	A. Holliday Street and number)	4b. City, Town, or Location of Dea Baltimore City		Day Year
Funeral Director		5. Social Security Number 6. Security 212-32-7715 Usual Residence of Decedent	x 7. Age (In yrs. last birthda)] M 2⊠ F 99 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) 1905 West Virginia
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Important: If tiern 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, If a Medical Ever it wit must be inclined at once.	Funeral Director	10a. State 10b. County Maryland N/A 10e. Street and Number	10c. City, Town or I	ore City	10	10d. Inside City Limits 1 ☑ Yes 2 ☐ No g. Citizen of What Country?
ath with	rai Di	4111 White Aven		21206		U.S.A.
ours after de rai', or itams	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
within 72 hc	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	(Giv College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of wo DO NDT use retired)	orking 1	6b. Kind of Business/Industry
d 2 should be liled within 72 hours aft and Mental Hygiene. 77 is marked other than "natural", or traumatic event, it a Medical Euro.	To Be Co	8 yr s 17. Father's Name (First, Middle, Last) John	P. Arthur	ome maker 18. Mother's Na Bet	me (First, Middle, M	Own Home aiden Sumame) Combs
and 2 sho ealth and 1 m 27 is me		19a. Informant's Name/Relationship (T) Maxine N. Milburn	- Daughter 2827	iling Address (Street and Number or R Bauernwood Avenu	ue Baltim	ore, MD 21234
permit. Pages 1 ar Department of Hea mportant: if Itam any injury or otha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Gardens			Oc. Location - City or Town, State Baltimore, MD
permit. Departi importi any inj		21. Signature of Funeral Service Licens Faul L. Clark	toal It	Leonard J. Ruck,	Inc. 530	
Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	nter the mode of dying, such as cardia	c or respiratory arres	Approximate Interval Between Onset and Death
te be ysicie	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed b		Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death? : 2∭No 3□Probably 4□Unknown
	Completed by				24a. Was an autopsy perform 1 \(\text{Yes} \) 2	
Physician: T this certificat ral director, ps	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{N} \) No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ath <i>(Check only one</i>	
<u>ਦੂ</u> ਦੂ <u>ਭ</u>		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	rsing Home 5 € Residence 6 □ Other (Specify) 28d. Describe how injury occurred			
To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town,	
e Hosp 124 hou a Funa letely fi	Medical	29a. Certifier 1 Certifying Phy- (Check only one) 2 Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred the control of the cont	e, and due to the cau urred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier		29c. License number		d. Date signed (Month, Day, Year)
3-10	2.	30. Name and address of person who will NOY KLUSSZ	mpleted cause of death (Item 23a) (Type (Cost Seam 1 Lesgith)			6/14/05-
Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	boote	7.10	

DHMH 17 Rev 1/2001

			For State Registrar		State of M	aryland / [artment of H rtificate of		d Mental H	ygien Reg. N		
	Physici /Medi		1. Decedent's Name Cur	(First, Middle, Las tis	t)			Jones		2. Date of D Month	eath D	2005	3. Time of Death 1
	Examir Funeral Director		4a. Facility Name (If r F(ank / i 5. Social Security Nur 425-54-84	n 5940	ire Hos	1	rthday) Yrs.	4b. City, Town, o ROSC If Under 1 Year Months Days	dale If Under 24		irth E	BCI + i M 9. Birtl -32	
	pur 🛊		Usual Residence of D	Decedent 10b. County		10c. City, Tow	m or Lo	cation					10d. Inside City Limits
	Aaryla f sho	ō	Md.	N	À	100. 01.9, 101.		Ltimore					1 Yes 2 □ No
	1 the 1	rect	10e. Street and Numb	per				10f. Zip Code			10g. C	Citizen of What Co	untry?
	238 o	al D	l Eastern	Ave.				2122	1			USA	
Maryland 21215-0036	n 72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show affeat Examinational be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces' 1 \textstyre Yes 2 ☐ If Yes, Give Year or Dates:	?		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Hispanic Origin an, Mexican, F Specify:	? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, White Specify: B	
5-0	n 72 ho "netur	Completed	(Specify	5. Decedent's Ed	ucation de completed)	16a	(Give	dent's Usual Occup kind of work done	during most of	working	16b.	Kind of Business/l	industry
121		ldm	Elementary/Second		College (1-4or	5+)	life.	DO NOT use retired Laborer	d)			ale Duni	d
d 2	filed Hygi other		11th gra 17. Father's Name (F					naborer	18. Mother's	Name (First, Middl		elf-Empl	oyeu
<u>la</u> n	and be dental rked o	To Be	Unkn						Opł	nelia		Jo	nes
ary	s 1 and 2 should be t Health and Mental ttem 27 le marked c other treumetic eve		19a. Informant's Nam	ne/Relationship (7	ype, Print)	196	. Mailir	ng Address (Street	and Number o	or Rural Route Num	ber, City	or Town, State, Z	lip Code)
	를 C =		Cheryl Jo		Daugh					Baltimor			
Baltimore,	0 0			Cremation 3 🗆	Removal from State	20b. Place o cemete	it Dispo iry, crer	sition (Name of natory or other plac	сө)	Date	20c.	Location - City or	Fown, State
Ħ			* 4 ☐ Donation 5			Garr		n Forest		6-20-05		wings Mi	
Ba	permit. Departr Importe any inju		//www	m /			4	March F.		Balti 1101		, Ma. 2 North Av	1202
	rnysician /Medical Examiner	ner	23a. Part Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list condition and list conditions. Enter Underly Caus. Enter Underly Caus.	inal	a. D (a) Due to (or as	_	0f):			rdiac or respiratory			Approximate Interval Between Onset and Death
Box 68760,	aath certificate be executed attending physician and for use as the burial-transit	n/Medicai Examin	that initiated events resulting in death) La	ist	d23c. If yes, outcome			ion.				23d. Date of delir	very
o.	s that the death ned by the atte or detached for	Physician/M	in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	ionths?	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ∏Fetal death it time of death		Ectopic pregnancy Other (specify)	ý 	42		Month	Day Year
ords, P	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	by	Part II. Other signific	ant conditions co	ontributing to death I	but not resulting i	n the u	nderlying cause giv	ren in Part I.		Yes :		the cause of death?
of Vital Records,		Completed								24a. Wa auto pen 1 🗆 Yes	s an opsy ormed? 2 X N	prior to c death?	topsy findings available ompletion of cause of
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referre examiner?	17	Hospital:			Oth	000	Death (Check only			
	g Phye er this eral di	n; To	1 ☐ Yes 2 🔏 N 27. Manner of Death	0	28a. Date of Inj	ury 28b.	Time of	it 3∐ DOA	4 Nursii	ng Home 5 🗆 Res 28d. Describe			ify)
ion	ath. r: Aft	atio	1 Natural 2 Accident	5 Pending investigation	(Month, Da	iy rear)	Injury		rk? Yes 2 □ No				
Division	el or Attending P s after death. sl Director: After t ed in by the funera	Certification:	3 Suicide 4 Homicide	6 Could not be determined	289. Place of in	jury - At home, fa tc. <i>(Specify)</i>	arm, str	eet, factory, office		28f. Location City or To		and Number or Ru te)	ral Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai C	29a. Certifier 1 (Check only 2 one)	Certifying Phy	ysician: To the best iner: On the basis of and manner s	of examination an	e, death	n occurred at the tir vestigation, in my o	me, date and p ppinion, death o	place, and due to the	cause(, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and til	tle of certifier				29c. Licens	-			ate signed (Month	
)	X		1 4.	Mara				RES	000		61	112/200	5
H	X '		30. Name an indexes You and a 31. Date filed (Month)	ATalo	ompleted cause of	9000 F	Type,	Print) Klin Squ	are dr	ive Balt	mo	re MD,	21237
	Sta Registi		J. Date filed (World)	JN 1 5 20	05 Jack	La Signature	Apr	orle					

ORIGINAL

Jones Curtis

			For State Registrar		State o	f Marylaı		artment <i>rtificate</i>				lental H	ygien Reg. N	200	15	19915
	Physic	0.0	1. Decedent's Name		")							2. Date of D	eath		rear	3. Time of Death
	/Medi			Paul			Ja	mes				June		2005	ear	07:49 p.M
1	Exami	ner	4a. Facility Name (If I 1414 Stray	not institution, give wflower R	oad, A	mber) partmen	ıt F	4b. City, T Ess		Location	of Death		4	c. County of Balt		e County
	Funeral Director		5. Social Security Nu Unkn		x QM 2□F	7. Age (In yrs.	. last birthday) Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth la <i>y</i> , Yea. 1–41	r) §	9. Birthpl Coun	ace (State or Foreign try) N.Y.
	pu >		Usual Residence of D	Decedent 10b. County		10- 0	ity, Town or Lo									
	Aaryia sho ed al	ō	Md.	Balt:	imore	100.0		ssex							10	Od. Inside City Limits Yang 2 No
	the N 28a-	rect	10e. Street and Num		LINOLC			10f. Zip (Code			-	10a C	itizen of Wh	at Count	
	3e or			raw Flowe	er Rd.	Apt.	F	101. 210	212	21			10g. 0	USA	at Court	u y r
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show the Mudical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Marrier 3 Widowed 4		12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	edent Ever in Urces?	J.S. 13.	Was Decede f Yes, specif		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	14. Race -	America White, 6	etc.
9	thou	ed t	1	15. Decedent's Edi	ıcation	ates.	16a. Dece	tent's Usual	Occupa	tion			16h	Kind of Busi		
Maryland 21215-0036	s 1 and 2 should be filed within 77 f Health and Mental Hygiene. item 27 is marked other than "ni other traumatic event, the Marial	Be Completed	(Specify Elementary/Second	y only highest grad	College (1	-4or 5+)	(Give life.	kind of work DO NOT use	done d retired)	uring mos	t of worki	ng			11033/110	usily
d 2	filled Hygid Sther ent, III	e Co	17. Father's Name (F	First, Middle, Last)	IVA		Tru	ck Dri			er's Name	(First, Middle		D L n Sumame)		
<u>la</u> n	should be nd Mental marked o	To B	William			J	James				innie				usti	.n
lary	2 sholl and h		19a. Informant's Nan	ne/Relationship (T	/ре, Print)		19b. Mailir	g Address (Street a	nd Numbe	er or Rura	l Route Numi	oer, City	or Town, St	ate, Zip	Code)
≥,	and ealth m 27		Pastor Pe		ing	Pastor				y Rd.		kesvil	le,	Md.	212	208
Baltimore,	iges 1 t of H : If ite or ot			Cremation 3 1			Place of Dispo cemetery, cren	sition (Name natory or oth	e of er place	9)	D	ate	20c. L	_ocation - Ci	ty or Tov	vn, State
Ħ	artmer artmer ortent injury		* 4 ☐ Donation 5	Other (Specify)		Mt	Carm	el Cen			5-11-			ndalk,		
Ba	permit. Pages 1 and 2. Department of Health as Importent: If item 27 Is any injury or other traugone.		▶ ₩ 3	adus	$^{\circ}$ ω $_{\circ}$	men					,			nore, North		21202
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atthrocule of Cause (Final disease or condition resulting in death)										arrest,			Approximate Interval Between Onset and Death
	D #	ner	Sequentially list conditions, leading to immorause. Enter Underly Cause (Disease or in	ditions, nediate ying	Due to (or as a consec	quence or):						,,,,,			
	icate be executed physician and the burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La		Due to (or as a consec	wanno of):									
8760,	be ex	aE	,			or as a conseq	(derice of).									
687		edical			d											
P.O. Box	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	ionths?	1 🗌 Live bi	come of pregna irth 2 Feta ant at time of d	al death 3	Ectopic pred Other (spec						23d. Date o Month		y Day Year
	w requires that been signed t should be det	by	Part II. Other signific	ant conditions co	ntributing to de	eath but not res	sulting in the ur	derlying cau	ise giver	n in Part I.			tobacco Yes 2		rte to the	cause of death?
I Records,	The ate h page	Completed										24a. Was auto perfo		prio	r to com	sy findings available pletion of cause of
Vita	icien: Th certificate ector, pag	Be	25. Was case referred examiner?	i .	lospital:							(Check only				
of Vital	Phys r this ral dir	: To	Yes 2 □ No 27. Manner of Death	0	1 🗆 1		ER/Outpatient		Other	4 1901		ne 5 🚣 esi 8d. Describe			(Specify)	
Division	Attending Physicien: r death. sctor: After this certification the funeral director.	Certification;		5 Pending investigation	(Monti	f Injury h, <i>Day Year)</i>	Injury	M	i. Injury a Work? 1 □ Ye	es 2□N		od. Describe	now inju	ry occurred		
Visi	Attendi ar death. ector: A by the fu	tifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	of Injury - At ho	ome, farm, stre	et, factory, o	office		2	8f. Location (Street ai	nd Number o	or Rural i	Route Number,
Ö	Itel or rs efte el Dir	Cert	T TICINICIO		buildir	ig, etc. (Specif	<i>y)</i>					City or To	wn, State	9)		
	To the Hospitel or Atterwithin 24 hours efter de To the Funerel Directo completely filled in by the	edical	29a. Certifier 1 (Check only 2 one)	☐ Certifying Phy Medical Exemi	sicien: To the ner: On the ba and mann	isis of examina	owledge, death tion and/or inv	occurred at estigation, in	the time my opi	, date and nion, deat	d place, a h occurre	nd due to the d at the time,	cause(s date an) and manne d place, and	er as stat	ted. he cause(s)
	To the Comp	Ň	29b. Signature and tit	le of certifier					icense					te signed (A		
-	0		The	odu. l	611	c/ ~2	()		OCME				Jur	ne 7,	2005)
/	5		30. Name and addres	s of person who co	mpleted cause	eath (Iten	n 23a) (Type, F	rint) 111 Pa	enn	Stre	et 1	Baltimo)re	Marvil	and	21201
C	بر Sta	to.	31. Date filed (Month,	Pax Year) - 0		*							,			
	Registr	11N 15 7005 E														

			State of Maryland / Department of Healt		ental Hygie	ene	
			1 - State Certificate of Dea	ath		. No. 2005	19916
	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic		horraine Johnson		6	12 05	dilspm
~	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat		-	4c. County of Death	
				Inder 24 Hrs.		N.	/ /Y
	Funeral			ours Min.	8. Date of Birth (Month, Day, Y	(ear) Cour	place (State or Foreign htry)
	Director		Usual Residence of Decedent		JUNE 13.	1725 191	HCYLAND
	/land		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Man	tor	MARYLAND N/A BALTII	HOR	E CIT	-1	Yes 2 No
	r 28g	Director	10e. Street and Number 10f. Zip Code			Litizen of What Cour	ntry?
	th wit	aiD	614 NORTH APPLETON 2	121	7	USA.	
	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show the M. dical Examir er mat be multised at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mey	ic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
ထ္ထ	or It		1 □ Never Married 2 □ Married 1 □ Yes 2 ◯ No	ecity:	, , , , , , , , , , , , , , , , , , , ,	Specify: B	
8	ural',	d by	3,⊠Widowed 4 □ Divorced Year or Dates:			DL	ACK
21215-0036	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	ng 16	6b. Kind of Business/In	dustry
2	withir ene. than	ш	Elementary/Secondary (0-12) College (1-4or 5+)	SSISTA	NT K	ESCULLER AL	ursing Home
	be filed tal Hygie d other event, II				(First, Middle, Ma		ASING INTE
aŭ	d be ental red o	o Be	GEORGE L. SMACKUM M	1VRT	Z	PINVE	
Maryland	should nd Men marke marke	욘	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	lumber or Rura	i Route Number, C	City or Town, State, Zip	Code)
≅	and 2 sauth ar n 27 la ner trau		BARBARAWILSON COAUGHTER) 3577 SHAN	. 1	DRIVE 1	BAIT M	101013
ē,	- 4 4 5		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		ate 20	c. Location - City or To	own, State
altimore,	permit. Pages Department of I Important: If it any injury or o		1. ■Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) GARRISON FOREST	706-11	-05 /	Bullates 1	1115 010
₫	artme ortan injur						
B	permit. Departr Importa any inj		21. Signature of Funeral Service Licensee 22. Name and Address of F	H. OK	AVE	BALTO, 1	10 21217
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, sucl				Approximate
	O manada in manada in manada in manada in manada in manada in manada in manada in manada in manada in manada in		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	<i>C</i> ,			Interval Between Onset and Death
ř.	Pnysician /Medical		disease or condition resulting in death) a. Small (x) (arcinoma a Due to (or as a consequence of):	, t (i	rng	-	1420
н	Examiner		Sequentially list conditions b.				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
	ransi	Examin	that initiated events c.				()
ó,	e exe ian a urial-	Ë	resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dicai	d				
9	ertific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Вох	ath c	ian/	23b. Was decedent pregnant in the next 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of delive Month	ery Day Year
0	The law requires that the death certifii tte has been signed by the attending rage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown				
<u>a</u>	that the	^A	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.	23e. Did tobar	cco use contribute to the	ne cause of death?
Vital Records,	signed be del	1 by			1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Ö	w require been si should t	Completed		-	24a. Was an	24h Wara auta	psy findings available
3ec	has has ge 2 s	ш			autopsy performe	prior to co	mpletion of cause of
a					1⊡ Yes 2√	No 1 ☐ Yes	2 No
Ħ.	Physician: this certific ral director.	Be	examiner?		(Check only one)		
o	Phys	. To	1 inpatient 2 EH/Outpatient 3 DOA 45		ne 5∐ Residend 28d. Describe how	ce 6 □Other (Specif	y)
o	ding h. After fune	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?			,,	
Division of	Attending It death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	-		et and Number or Rura	il Route Number,
Ω̈́	al or Attend safter death f Director: / d in by the f	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, dat	ate and place, a	and due to the cau	se(s) and manner as s	tated.
	ne Ho n 24 l ne Fu sletel)	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	n, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To the I within 2 To the I complet	ž	29b Signature and title of certifier 29c. License number 29c. Lice	mber	29d	I. Date signed (Month,	
)	//	>	1 (Cull 47) 743	386		6-14-05	
4	11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		•		
_)		Penial R. Howard 1714 Lutaw	Pluc	4 Ba	l'in more	M7 21217
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penial R. Howard (714 Europe 31. Date filed (Month, Day, Year) 32. Registrar' Signature			,	

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13, 2005 **Physician** Month Year June John O. Jones 2:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA 2651 S. Paca Street Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day,) | O9-05-1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director Yrs. North Carolina 238-46-0908 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumetic evant, its Medical Examiner must be notified at 1XXYes 2 □ No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s any injury or other traumetic event, the Medical Examiner must. Quee. 2651 S. Paca Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Curtis Steel Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rosa Jones Thomas Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria D. Curtis-Jones Wife 2651 S. Paca Street Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery 06-17-05 Lansdowne, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N.Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Pan creatic Proysician Metastatic Zmos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leaving a immediat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the sid be detached f 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Cther: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 👿 No 2 ER/Outpatient 은 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To tha Funaral Director: / completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hanover St. Baltimore 3001 oung 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 5 2005 Registrar

			1 = For State Registrar	State of N	Marylan		artmen rtificate			and M	-	giene (05	19918
	 Physici	an	Decedent's Name (First, Middle,	•							2. Date of De Month	Day	Year	3. Time of Death 2: AM
	/Medic	al	STEVEN			CKSON	4 02	-		15 1	6/3/			
	Examin	er	4a. Facility Name (If not institution, (HOME) 1835 F	*					Location of	of Death		4c. Cour	nty of Deat	h
	Euparal				'REET	last birthday)	If Under		If Under	24 Hrs.	8. Date of Bir	th	9 Birt	hplace (State or Foreign
Н	Funeral Director		220-15-7102	1 ∑ M 2□F	31	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 9 / 22	y, Year) /73	Co	MD.
	p. ,		Usual Residence of Decedent											
	anylau show	7	10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits
	he M 28a-f	Director	MD .			BALT								Yes 2 No
	with I	ā	1835 E.31st	STREET			10f. Zip		110			10g. Citizen o		ountry?
	ns 23	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.	.S. 13. 1	Was Deced	212 lent of Hi		ain? (Spe	ecify Yes or No		ISA ace - Ame	rican Indian,
ပ္	or Her		1√2 Never Married 2 Marrie	Armed Force	s?	1				, Puerto	ecify Yes or No Rican, etc.)	В	lack, White	
03	72 hours after death with the Maryland natural', or Hems 23a or 28a-f show dical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates	s:		1 ☐ Yes 2	X 25	Specify:			Spec	eify: E	BLACK
21215-0036	"natu	Completed	15. Decedent's (Specify only highest			16a. Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa	tion <i>Juring m</i> os	t of worki	ng	16b. Kind of	Business/	Industry
121	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4o	or 5+)	Skil						Conot		
d 2	e filed val Hygie other t	ပိ	12 17. Father's Name (First, Middle, Li	ast)		DKII.	T MOI	rker		r's Name	(First, Middle	Const		,10n
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at a.	To Be	Calvin Lee Ja	ackson					Debi		Jean .		/	
ary	2 should be and Mental Is marked of raumatic eve	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	or or Rura	I Route Numb	вг. City or Tow	m, State, Z	Tip Code)
	Health a tem 27 ls		DEBRA J. JAC	KSON		1835	5 E 3	1.S	Т. В	ALT	O. MD.	2121	8	
ore	of He		20a. Method of Disposition **Description** **Descriptio	∃ ∏Removal from Sta		lace of Dispo emetery, crer	sition (Nam natory or ot	ne of ther place			ate	20c. Location	n - City or	Town, State
Baltimore,	Pages tment of tant: If it jury or o		* 4 ☐ Donation 5 ☐ Other (Spe	ecify)	C	edar 1			-	· · · · ·	2005	Balti	more	e, Md
Bal	permit. Pag Department Important: I any injury o once.		21. Signature of Fineral Service-Li	Coty	9	22	ESTE I300	Addres			ERAL E	OME P	.A. ₂	1217
ı	- GA		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus nly one cause on tach	ed the death	h. Do not ent	er the mode	of dying						Approximate Interval Between
	Physician			Onset and Death 2 ms										
	/Medical Examiner		resulting in death)	Due to (or a	as a conse	uence of):	neun							
н		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequ	(STATIC	th	yma	na					275
	d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury	(0.10			4	,						·
oʻ	exectan and and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or a	as a consequ	uence of):								
8760,	death certificate be executed eattending physician and of for use as the burial-transit	Physiclan/Medical	,	d										
9	e as t	Med	IF FEMALE:											
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 🗆 Fetal	Ideath 3□	Ectopic pre						Date of deli Month	very Day Year
o.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5∟	Other (spe	ecity)						,
Δ.	The law requires that the tee has been signed by the bage 2 should be detached.		Part II. Dther significant condition	s contributing to death	but not resi	utting in the ur	nderlying ca	iuse give	n in Part I.	-	23e. Did t	obacco use co	ntribute to	the cause of death?
rds,	quires n sign	ed by									1 🗆 '	Yes 2□No	3 🗆 Pro	obably 4 Unknown
000	aw requir s been si s should	plet									24a. Was		. Were au	topsy findings available
Vital Record	ystcian: The laviscentificate has	Completed									autor perfo	rmed? 2 35 No	death?	ompletion of cause of
/ita	ilcian: Th	Be (25. Was case referred to medical examiner?							of Death	(Check only o			
of	Attending Physician: r death. ector: After this certific. by the funeral director.	²	1 ☐ Yes 24 No			ER/Outpatien			4 🗀 Nu	rsing Hor		dence 6 🗆 O		rify)
nc	ding F h. After funer	lon	27. Manner of Death	28a. Date of In (Month, D	Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	at ? ′es 2 ⊟ t		28d. Describe I	now injury occi	urred	
Division	or Attendate death Director: in by the	ficat	2 Accident investiga 3 Suicide 6 Could no	t be 380 Place of I	niury - At ho	ome, farm, stre					28f. Location /	Street and Nun	nher or Ru	ral Route Number,
2	al or / s after il Dire d in b	Certification:	4 Homicide	building,	etc. (Specify	1)	,,			J.	City or Tov			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Check only 2 Medical E	Physician: To the besi	st of my kno	wiedge, death	occurred a	t the tim	e, date an	d place, a	and due to the	cause(s) and r	nanner as	stated.
	To the H within 24 To the F complete	le dical	one)	kaminer: On the basis and manner	stated.					n occurre				
	To with	Σ	29b. Signature and title of certifier	. 11			29c.	License	number	9 0		29d. Date sign	ed (Month	, Day, Year)
	[1]		Ha	u			P	PP	611	10		6	1/0	3
	b		/	no completed cause of	death (Item	14.	Print)	m	0	212	-31	1	t	
	Sta	te	31. Date filed (Month, Day, Year)		strar's Signa	200				-				
	Registra	ar	JUN 1 5	2005		4 1	and i							

DHMH 17 Rev 1/2001

ORIGINAL

Physici		Decedent's Name (First, Middle		C Ja	mison			2. Date Mon JUNI	of Death	005	Year	3. Time of Dea 5:57 P		
/Medid Examin		4a. Fecility Name (If not institution,	give street and num			4b. City, Town, o	or Location of De		4	4c. County of		J.J. 1		
		WB I-70 EAST O		. Age (In vrs.	last birthday	LISBON If Under 1 Year	If Under 24 H	rs. R Date		HOWAR1		ace (State or Fo		
Funeral Director		245-50-5653 Usual Residence of Decedent	1⊠M 2□F	69		Months Days	Hours Mi	n. (Mon Se	of Birth th, Day, Yea ep 2, 193	35	Coun	V. C.		
wohe to the total		10a. State 10b. County		10c. Ci	ity, Town or L						10	Od. Inside City Lin		
28a-f e	ecto		altimore				altimore		- 10			1 Yes 2		
3a or 3	Funeral Director	10e. Street and Number 5521 Wesley Avenue				10f. Zip Code	21207		10g. C	Citizen of W	U.S.A.	iry?		
ams 2	nera	11. Marital Status	12. Was Deced	dent Ever in U	J.S. 13.	. Was Decedent of H If Yes, specify Cubi	Hispanic Origin? an, Mexican, Pue	(Specify Yes erto Rican, et	or No- c.)		- America			
f, or h	by Fu	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tyes 2 If Yes, Give Year or Dat			1 ☐ Yes 2 ☒ No		,	,	Specify:		ack		
natura lical E	ted	15. Decedent' (Specify only highes	's Education		16a. Dece	edent's Usual Occup e kind of work done	pation	yorkina	16b.	Kind of Bus	siness/Ind	ustry		
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am 27 is		Dorothy Jamison Wif	e			521 Wesley A								
	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 X Removal from Si		Place of Disponentery, cre	osition (Name of ematory or other plac	сө)	Date			-			
= 5							7/05 Fairmount, N. C.							
rant: I		* 4 □ Donation 5 □ Other (Sp.			T	rmont Cemete		06/17/0	Jo	zzie Thompson mber, City or Town, State, Zip Code) 21207 20c. Location - City or Town, State Fairmount, N. C. ce PA Md 21217 y arrest, Approximate				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Alice Jones 4:35 p Jun 11, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner **Baltimore** N/A 524 North Charles Street-Apt 1313 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2/C F Director 215-30-2952 N. C Nov 11, 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow treumatic event, the Medical Examiner I was be notified at Baltimore 1 Yes 2 No Director N/A Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 524 North Charles Street 21201 U.S.A. or Iteme 23e Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Give þ If Yes, Give Year or Dates: Black 3 X Widowed 4 ☐ Divorced neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry t and 2 should be filed within Health and Mentat Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City** Dietitian 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Smith Cora Worley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 1213 North Eutaw Place Baltimore, Md. 21201 Lavoy Jones Son other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent; If ŏ 06/21/05 Owings Mills, Md. Garrison Forest Veterans Cemetery ⁴ 4 ☐ Donation 5 Other (Specify) 21. Signatur o Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. $oldsymbol{b}$ o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerofic Physician /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, beauting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duá fo (or as a consequence of) Examine The law requires that the death certificate be executed insetes burial-tran Due to (or as a consequence of): 68760 Physiclan/Medical the attending IF FEMALE: Box esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown percholesterolemia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy performe 2 No 1 ☐ Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 X No 1 Tyes ot 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. 28b. Time of 28d. Describe how injury occurred After t Certification: Injury at Work? To the Hospital or Attending Division 1 Natural 5 Pending Injury death. investigation 1 Tyes 2 🗌 No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Direct 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatule 053517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 SAINT PAUL PLACE PROFESSIONAL OFFICE BUILDING 907 Boltimor Hayland lague M.D ARNEL MENDOZA 31. Date filed (Month, Day, Year) State JUN 1 5 2005 Registrar

			For Amend Item 2	state pellan	land Sp pa Cei	of 715/05di tificate of D	alth and leath	Mental Hyg	iene2 () (5 19921
	01 - 12		1. Decedent's Name (First, Middle, Last)					2. Dete of Deat Month	h	3. Time of Death
	Physici: /Medic		Nolan Jans	on				May 25	2005	7:35 PM ^M
	Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or L		eath	4c. County of	
				ing Drive		Baltin	nore	rs. 8. Date of Birth		imore
	Funeral		5. Social Security Number 6. Sec 144-01-2823	M 2DE	n yrs. last birthday) O Yrs.	Months Days	Hours M		, 1915	9. Birthplece (State or Foreign Country) New Jersey
	Director		Usual Residence of Decedent		89 Yrs.			Julie 29	, 1915	New Jersey
	yland W H		10a. State 10b. County	10	C. City, Town or Lo	ocation				10d. Inside City Limits
	Mar Mar	ţo	MD Baltin	nore	Balti	mroe				1 ☐ Yes 2 ☐ No
	or 284	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	within 72 hours after death with the Maryland ene. Than *natural*, or Items 23e or 28e-f show the Madical Examiner must be notified at	al	1404 Browning	g Drive #A		212	21			JSA
	r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? , Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.
9	or if	by Fu	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give	10.15	1 ☐ Yes 2🏋 No	Specity:		Specify:	white
21215-0036	ursi'	d b	3 Widowed 4 □ Divorced 15. Decedent's Edu		43-45	dent's Usual Occupat	ion	unk	16b. Kind of Busi	ness/industry
다 스	n 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done du DO NOT use retired)	ring most of v	working	TOD. INITIO OF DUST	nosari dustry
7	thar thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)					construc	ction
0	filed with Hyglene. other than	BeC	17. Father's Name (First, Middle, Last)			unk	18. Mother's N	lame (First, Middle, I		
ᇤ	ked be	To B								
Maryland	should be and Mental marked o umatic eve	, T	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street ar	nd Number or	Rural Route Number	, City or Town, St	tate, Zip Code) unk
	and 2 ealth a n 27 ls		Bertha Gonzalez/	friend						
e,	of Herm Item		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	,	Date	20c. Location - Ci	ity or Town, Stete
Ĕ	Peges nent of I ant: If It ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	in state	7					
	permit. Peges 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important if them 27 is marked other than 'natural', or itams 23e or 28e-f show any injury or other treumatic event. In a Madical Examinat must be notified at any injury or other treumatic event.		21. Sign ture of Funeral Service Licens Ronald S. I	99 //	tor / SI	2. Name and Address tate Anato altimore,	my Boa	rd 655 W.	Baltimo	re Street
	*		23a. Part i Enter the disease, or como shock or heart failure. List only o	ications that caused the					est,	Approximate Interval Between
.7	nysician		Immediate Cause (Final	MIA acas	lal In	fortin				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c	onsequence of):	(41-)1113				
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	ocuted nd transi	Examine		c		200				
Ŏ,	be executed icien and burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					
87	eath certificate be executed attending physicien and for use as the burial-transit	Physician/Medical	•	d						
9	death certificate e attending phys d for use as the	Me	IF FEMALE:	23c. If yes, outcome of	Orognanov.				004.0	of deliner
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 [4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ie oi death - 5 L	Other (specify)				
۵.	faw requires that the de as been signed by the a 2 should be detached to		Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	inderlying cause giver	n in Part I.	23e. Did to	pacco use contrib	oute to the cause of death?
ds,	sign d be	d by						1 🗆 Y	s 2 No 3	Probably 4 Unknown
Vital Records,	w require been si should t	ompieted						24a. Was a	n 24b. We	ere autopsy findings available
Re	0 - 0	E G						autops perfori	y pri nęd? de	ior to completion of cause of eath?
a	icien: Th certificate ector, pag	ပိ	25. Was case referred to medical				Of Disease of I	1 ☐ Yes Death (Check only on		Yes 22No
		o Be	avaminar?	Hospital:	2 ER/Outpatie	Otho		g Home 5 X Reside		(Specify)
o		1	27. Manner of Death	28a. Date of Injury		ow injury occurred				
Division	Attending I r death. ector: After by the funer	恴	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	? es 2 □ No					
Visi	Attendi	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (28f. Location (S. City or Town		r or Rural Route Number,			
	el or Att s after d al Direct ad in by	Cert	4 Homeda	building, etc. (Sp o city)			ony or roun	,, 0.12.0)	
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b	edical (rsician: To the best of r iner: On the basis of ex and granner state	camination and/or in					
	To the within 2 To the complet	Æ	29b. Signature and title of countries	1		29c. License	number	2	9d. Date signed	(Month, Day, Year)
)	->-0		V 4/14-1/11	1		R581	8		5/29/	5
			30. Name and address of person who d	completed cause of dea	th (Item 23a) (Type			1 1 -	1-11	7
			ETHAN HASKEL	F	RANKUIN	Print) SOUMDE	105	oital (ex	Her	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature /	(1)	1			
	Regist	rar	JUN 1 5 2005	Beech !	12. When	gav.				

			For State	State of Ma	aryland /	-				and M	ental Hy	gien	е	
		_	Registrar 1. Decedent's Name (First, Middle, Last)			Cer	tificate	Of L	<i>Jeatn</i>		2. Date of De	Reg. N	<u>~ 005</u>	19922
	Physici	an									Month	Da	/	3. Time of Death
	/Media		Alberta D Knell 4a. Facility Name (If not institution, give s				4b. City, T	own or l	Location o	of Death	June		C. County of Death	631 PX
4	Examir	ier	Good Samar.	\ . A	osoi to	1	Ba		mo			"	Belt	more
	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last b		If Under 1	Year	If Under:	24 Hrs.	8. Date of Bir (Month, Da	th	9. Birthp	lace (State or Foreign
	Director		219 28 2866	M 2□F 71	L	Yrs.	Months	Days	Hours	Min.	Februar		1934 Chio	try)
	pur ≱≋au		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	um or Lo	cation							Od. Inside City Limits
	Aarylan f show	ō											'	1 ☐ Yes 2 ☐ No
	the A	Director	Maryland Baltimore 10e. Street and Number		Baltimo	ore C	10f. Zip C	Code				10a C	itizen of What Coun	X
	3a or		7811 Daniels Avenue				212							,
	death ms 2	Funeral		12. Was Decedent I	Ever in U.S.	13. V	Vas Decede	nt of His	panic Orig	gin? (Spe	cify Yes or No	US ₂	14. Race - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exament must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 27 N If Yes, Give Year or Dates:	No		Yes, specif		Specify:	i, Puerto I	Rican, etc.)		Black, White, Specify: White	
9-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	168	a. Deced	lent's Usual kind of work	Occupat	tion	of worki	20	16b. I	Kind of Business/Ind	
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	lite. L	OO NOT use	retired)	iring mosi	OI WOIKII	'y			
2	filed with Hygiene. other than	Cor	10	N/A	In	ispect	or						pers Co.	ē
pur	be fil d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maide	n Surname)	
3	2 should be f and Mental if is marked of raumatic eve	T ₀	Albert V Demeron 19a. Informant's Name/Relationship (Ty)	nn (Brint)	101	d			Olive			0"	or Town, State, Zip	2:11
Maryland	d 2 sl th and 7 is r traur		Gloria Martin (Daughte				_				ore, Md.			Code)
	1 and 2 Health tem 27		20a. Method of Disposition		20b. Place of	of Dispos	sition (Name	of of			ate		ocation - City or To	wn, State
Baltimore,	9 = 10		1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State			natory or oth metery		iune 14	4 2001	5		timore,Mary]	
ij	permit. Pa Departmer Importent any injury		21. Signature of Funeral Service License	90	Lazzaio							ш	LIIIDIC 91 PALY	lai ti
ä	Depar Impor any ir		mother toose	h Cha	mik?		Name and ASSAM					.1	1 01000	
			23a. Part1. Enter the disease, or complishook, or heart failure. List only or	cations that caused	the death. Do	not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,	1 21230	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Dil	tic	Ca.	mive	1/6	Culcu	D	isease	Onset and Death
	/Medical		resulting in death)	•	a consequence		71.		V L U) V-	scuia	V -	G2-07	
	Examiner	Ш	Sequentially list conditions, b											
	b iii	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	ot):							5	
	cate be executed bhysician and the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a consequence of):										
8760,	be ey			000 10 (01 83 1	a consequence	5 01).								
687		de											Y	
. Box	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pred Other (spec						23d. Date of delive Month	ory Day Year
P.0	that the de led by the detached	Phy	Part II. Other significant conditions con	tributing to death by	it not reculting	in the ur	dorbing on	.00 51105	n in Port I		23a Did t	abacco	use contribute to th	na cause of death?
Vital Records,	w requires t been signe should be o	ted by	Covenavy	Arter	7	** (11 0 (11		256 GIV61	THI FORE			Yes 2		
ecc	e law r has be je 2 sh	Completed									24a. Was	osy	24b. Were autor	psy findings available inpletion of cause of
E B		Con									perfo	rmed?	death?	
/ita	ysician: is certific director,	Be	25. Was case referred to medical examiner?	e anital:							(Check only o			
of		2	1 Yes 2 No	ospital:									6 ☐Other (Specify)
Division of	ing After une	lon	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	M 286	Work?	?		8d. Describe	now inju	iry occurred	
Sic	deatl deatl ctor: / the	lical	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Numb								l Route Number			
Ω̈́	after d after d Direct d in by	Certification;	4 Homicide determined	building, etc	(Specify)	arring our	ot, lactory,	511100			City or To			7100107101007
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of nar: On the basis of and manner sta	examination at	ge, death nd/or inv	occurred at estigation, in	the time	a, date and nion, deat	d place, a	and due to the ad at the time,	cause(s date an	s) and manner as stand place, and due to	ated. the cause(s)
	To the Vithin 2.	Me	29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signed (Month, L	Day, Year)
) ,	11.		Lendie	Dro	en	mi	D	00	58	141		JU	ne 10	2005
	9		30. Name and address of person who co	Raver				alt	m	011	, mī	>	2123	3 9
E	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 5 20	30 D	ar's Signature						- *			•
				- College	-	-								

DHMH 17 Rev 1/2001

1 - State Registrer	!		Certificate of	Death	Mental Hygid	. No.2 0 0 5	19923
Physician /Medical	ne (If not institution, give street ar			or Location of Death	2. Date of Death Month JUNE	Day Year 8, 2005 4c. County of Death CARROLL	3. Time of Death 1:13 P. M
Funeral Director 218-07	′-5543 1□ м 💥	7. Age (In yrs. last bit	rthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	9. Birth <i>Col</i> 919 M/	nplace (State or Foreign untry) ARYLAND
Iter death with the Maryland Iter death with the Maryland Iter death with the Maryland Iter death with the Maryland Iter marginal Iter True Terms 23a or 28a-1 show The MD. 10a. State MD. 2 nd 11. Marital State XN Never	. AVENUE	Decedent Ever in U.S. ad Forces? Yes XXI No s, Give	SYKE			g. Citizen of What Cor U. S. A 14. Race - Amer Black, White Specify: W	ican Indian, o, etc.
2 should be filled within 72 hours a sand Mental Hygiene. Is marked other than "natural", o a mark	15. Decedent's Education Specify only highest grade comple	16a age (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire SALES C	pation during most of work d) LERK	e (First, Middle, Ma	6b. Kind of Business/l	NHITE ndustry STORES
19a. Informani 19a. Informani 19a. Informani 19a. Informani 19a. Informani 19a. Informani 19a. Informani 19a. Informani 19a. Informani		NIECE) 95	o. Mailing Address (Street 9 RADCLIFFE of Disposition (Name of try, crematory or other pla	ROAD, TO	WSON, MAR	City or Town, State, Z.	204
S S = 6 XX Burial '4 □Donat	2 Cremation 3 Removal		IEY VALLEY M 22. Name and Addre	.G. Ub-11-		IMONIUM, MA 1050 Y C. TOWSON	
Physician /Medical Examiner Sequentially lift any, leading	atth) at conditions, to immediate e or injury tents a	that caused the death. Do on each line. Let uv be to (or as a consequence to (or as a consequence to (or as a consequence)	of):		or respiratory arres	rt,	Approximate Interval Between Onset and Death
nat the death certificate be to the death certificate be to the attending physicii etached for use as the but etached for use as the but etached by the total physician/Medical Physician/Medical Physician/Medical	at 12 months?	s, outcome of pregnancy Live birth 2 □ Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of delia	very Day Year
Completed by the attending the death certain cate has been signed by the attending page 2 should be detached for use page 2 should be detached for use to the cate has been signed by Physician/M Completed by Physician/M Completed by Physician/M Completed by Physician/M Completed by Physician/M Completed by Physician/M Completed by Physician Co	ignificant conditions contributing to the year of security securit	w	n the underlying cause giv	ven in Part I.	1 ☐ Yes 24a. Was an autopsy performe	prior to co	./
	Death 28a. 5 Pending investigation e 6 Could not be determined 28e.	Date of Injury 28b.	Time of 28c, Injury Wo	ner: 4 □ Nursing Ho ry at rk?] Yes 2 □ No	28d. Describe how	ce 6 Other (Special injury occurred let and Number or Rui	
To the Hours of Check on the Hours of Check on the Funds of Check on the Hours of Check of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours of Check on the Hours				opinion, death occurr se number	red at the time, date		to the cause(s)
Shaw	17	cause of death (Item 23a)	(Type, Print)	The Ro		10 217	87

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 06/12/2005 Kathleen F. Kulacki 6:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 527 S. Washington Street Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Day, Year) 06/07/1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 XF Director 215-40-4256 63 Maryland Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland N/A Baltimore the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With ŏ 527 S. Washington Street 21231 238 United States by Funerai filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Packer Warehouse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Adam Jablonski Frances Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an tent: if item 27 is jury or other traur 527 S. Washington Street Baltimore, MD 21231 Richard Kulacki - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: if any injury or once. 4 Donation 5 Other (Specify) Holy Rosary Cemetery 06/16/05 Baltimore, Maryland 22. Name and Address of Facility Dayid J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, MD 21231 21. Signature Tuneral Service License 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC MECANOM 7 MO. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 99 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who complete of death (Item 23a) (Type, Print) 10753 FALLS RU #415, LUTHERVIC STONIO 31. Date filed (Month. Day, Year) State

Registrar

				State of Maryland / Department of H	lealth and M	-	_] =	19925
				1 - State of Many tarilor Department of A	Death		Reg. No.	<i>J</i>	. J J 6m V
		Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day	Year	3. Time of Death
		/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or	r Location of Death	6	4 6 600	05 nty of Death	12:40 A M
	1	Examin	er	T 0 0 1 1 1 1 7 (1)			4c. cou	ity or Death	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th Voarl	9. Birth	place (State or Foreign
		Director		219-60-6277 12 M 2 F 50 Yrs. Months Days	Hours Min.	8. Date of Bir (Month, Da 7 – 1 7	-54	DC	nury)
		and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
		Maryia f sho	ō	MD Baltimore					1 Nes 2 No
		death with the Maryland ms 23e or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code			10g. Citizen o	of What Cou	ntry?
		th with	ai D	106 Willowsprin Rd. 21222			USA		
		ems	ner	11. Marital Status Seperated. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. R	ace - Ameri lack, White,	
	36	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No				oify: Whi	.te
	9	tural	ed b	15 Decedent's Education 16a Decedent's Usual Occup	pation		16b. Kind of	Business/Ir	dustry
	215	nin 72	piet	(Specify only highest grade completed) (Give kind of work done life. DO NOT use retired.) Elementary/Secondary (0-12) College (1-4or 5+)	during most of work d)	ing			,
	212	d with	Completed	7th Highway Man			Publi		ks
	pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		, Maiden Sum	ате)	
	yla	d Men d Men narke	2		Ruby Ho	-	or City or Toy	n State 7i	o Codol
	Maryland 21215-0036	d 2 st th and 7 is n traun	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street. John Lambert (brother) 106 Willows				m, Siate, Zij	o code)
	ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of		Date	20c. Location	n - City or T	own, State
[,	ê E	Pages ent of nt: If i		1 □ Burial 2 X Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Bayview Cremat		0-05	Dunda]	lk, M	D
5/4	altimore,	permit. I Departm Importal any Injui		21. Signature of Funeral Service Licensee 22. Name and Addre	ss of Facility We	sley C	Chavis	Jr.	FH
4	Ö	9 9 E 2 8	US 1	Navolla, Hunter 2007 East	ern Ave	. Balt	o. MD	2123	31
~				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	M	Pnysician	4	Immediate Cause (Final disease or condition a. Brain hetastass					Onser and Death
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05			er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				-	Lyvs
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	3760,	ate be hysici	lical	d		<u> </u>			
+	x 68	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			004	Data of data	
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کے	٦,	w requires that th been signed by should be detacl	by Pł	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to I	he cause of death?
7	rds	w requires been signi should be		Suzurs		1 🐼	Yes 2□No	3 🔲 Pro	bably 4 Unknown
c)	ecord	law re as bed 2 sho	Completed			24a. Was	an 24t	. Were auto	opsy findings available ompletion of cause of
1-	α	. 60 0	Com			perfo 1 ☐ Yes	ormed?	death?	2□ No
7	Vital	ician: ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Deat				11
j	of	iing Phys	. To	1 Yes 2 No Pospital 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injur	ner: 4 ☐ Nursing Ho		how injury occ		W) Hospice
	o	ding h. After fune	tion	1 Natural 5 Pending (Month, Day Year) Injury Wor	rk? Yes 2 □No	200. 200000			(3)
ı	Division	I or Attendi after death. Director: A I in by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		28f. Location (Street and Nui wn, State)	mber or Rur	al Route Number,
	ā	s after al Dire	Certification:	4 Homicide determined building, etc. (Specify)		City of 10	wii, Statej		
		To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only C					
		To the k within 24 To the f complete	Med	one) and manner stated. 29b. Signature and title of certifier 29c. Licens	se number		29d. Date sign	ned (Month	Day Year)
)	T W S					(ls)	1-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		(T)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6880		0/4	105	
		10/		Harry M. Harris 300 Armory Place	suite 3	C Bul	Am,	1.21	20/
		Sta		31. Date filed Month, Day, Year) 32. Resistrar's Signature	<u> </u>				
		Regist	rar	JUN 1 5 2005 June 15 Sparte					

	1 - For State Registrar			Maryland / De	epartmen Certificat			and M		Reg. No.	005	1992
Physiciar /Medica	No.	Name (First, Middle 1bel E. La						!	2. Date of Dea Month	Day 19	Year 2005	3. Time of Death 6:04p. M
Examine	4a. Facility Na		n, give street and numb tian Street			Balt	Location o				unty of Death	re
Funeral Director	5. Social Secu 236-54		6. Sex 1 ☐ M 2 K F 7.	Age (In yrs. last birtho	Months	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Da May 10	y, Year)		place (State or Foreigr ntry) 1and
with the Maryland or 28e-f show	10a. State	10b. County Balt	imore	10c. City, Town o	ltimor		•					10d. Inside City Limits 1 X Yes 2 ☐ No
or 2	10e. Street an				10f. Zip					10g. Citizer	of What Cou	ntry?
72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show offsat Exacitrer coust be notified at	11. Marital Sta 1 Never 3 Widov		If Yes, Give Year or Date	XX No		2X No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	Sp	Race - Ameri Black, White	etc.
	Elementary/		college (1-4	(6	Give kind of wo fe. DO NOT us Pack	rk done d se retired	furing most	t of workir	ng		able P	*
be file	17. Father's N	ame (First, Middle, a 01en Bu							(First, Middle,			n
Defilitione, Marylia permit. Pages 1 and 2 should Department of Health and Mar Importent: If item 27 is market any injury or other treumetto once.	Thomas 20a. Method of 1 X Buria ` 4 □ Dona		/ Son 3 □ Removal from Sta	20b. Place of D	714 Gradisposition (Narcrematory or of Point 22. Name an	celar me of other place Cemend Address	nd Av	enue May 200		more, 20c. Locat Ke neral	MD 2 ion - City or T	1224 own, State
cate be executed by Sician and hysician and the burial-transit the burial-transit company.	shock, of Immediate Cadesease or corresulting in de Sequentially I if any, leading cause. Enter Cause (Disease that initiated a resulting in de Indiana Cause)	or heart failure. List aude (Final notition path) ist conditions, it is in mirediate Underlying se or injury wents	b. Due to (or	sed the death. Do not hine. Levin cas a consequence of on a management of as a consequence of as a consequence of on a management of on a management of on a management of one as a consequence of on	conter the mod	le of dyin	g, such as	cardiac o		rest,	2377	Approximate Interval Between Onset and Death Heav S
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	Completed								24a. Was	an 2	4b. Were auto	opsy findings available ompletion of cause of
hysicien this certifical director.	25. Was case examiner of 1 Yes 27. Manner of Natura 2 Accid 3 Suici	Death al 5 Pendir ent investi de 6 Could	Hospital: 1 Inp		ne of 2	28c. Injury Work	er: 4 □ Nu	rsing Hor	(Check only one Describe It	dence 6 now injury of	ccurred	fy) al Route Number,
Hospitel or 4 hours after Funerel Dii tely filled in	4 Homi 29a. Certifier (Check or one)	Gertifyir	building ng Physicien: To the be Exeminer: On the base and mapne	, etc. (Specify) est of my knowledge, one of examination and/	death occurred	at the tim	ne, date an	d place, a	City or Tov	vn, State) cause(s) an	d manner as s	stated.
To the within 2 To the complet		and tille of certifie		to, no			number	18			igned (Month,	Day, Year) 5 MO 2122
State Registra	a 31. Date filed	(Month, Day, Year)	Pinto, N	istrar's Signature	ZI E	Sens	son 1	4 ve	15a	ltim	ore,	MO 2122

			1- State of Management of Mana	aryland / Depa		Health a	and Mental Hyg	iene 1eg. No. 2005	19927
0			Decedent's Name (First, Middle, Last)			-	2. Date of Dea Month	_	3. Time of Death
	Physici /Medio		DORIS ANNETTA LONG					L2, 2005	8:21 PM
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location o	of Death	4c. County of Deatl)
		•	FREDERICK MEMORIAL HOSPI	ral	FREDE			FREDERI	
	Funeral Director		5. Social Security Number 577-28-3383 Usual Residence of Decedent 5. Sex 1 □ M 2 ☑ F 7. Ag	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day) Feb. 16,	9. Birth 1924 West	pplace (State or Foreign untry) Virginia
	land		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary fied	ō	Maryland Frederick	Fre	ederick				1 ☐ Yes 2 ☑ No
	7 28a	rec	10e. Street and Number	1	10f. Zip Code		1	l0g. Citizen of What Co	untry?
	h with	Funeral Director	6815 Yellow Sheave Court		2	1703		United Sta	tes
	deat	ner	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Orig	gin? (Specify Yes or No-	14. Race - Amer	
9	or ite	F	1 Never Married 2 Married 1 Yes 2 T	No	1 ☐ Yes 2X No		, ruento moan, etc.)	Specify: Wh	
933	ural',	d by	3X Widowed 4 □ Divorced Year or Dates:					Specify: 1111	
21215-0036	within 72 hours after death with the Maryland ane. than "netural", or items 23e or 28e-f show te Madical Examiret must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occu kind of work done	during most	of working	16b. Kind of Business/l	ndustry
121	within one.	m du	Elementary/Secondary (0-12) College (1-4or 5	5+)	DO NOT use retire Homemak	•		Own Home	•
	filed with Hygiene. other than	ပိ	17. Father's Name (First, Middle, Last)		nomemak		r's Name (First, Middle, i		<u> </u>
ano	ould be f Mental P mrked of	202	Russel Taylor				rie Swagger	marasii ourname)	
Maryland	should ind Men s marke umatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street		r or Rural Route Number	City or Town State 7	in Code)
Ma	nd 2 sho lith and 27 is mu treums		Kenneth Long/Son				, Frederick		
	Health tem 27 other tr		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Date	20c. Location - City or 1	
no	Pages nent of I ant: If its ary or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Fort Line	natory or other pla	ice)	June 16, 2005 B	Brentwood, N	Marv1 and
Baltimore,			21. Signature of Funeral Service Licenses		2. Name and Addre	ess of Facilit	Robert A. P	umphrev Fu	neral Home/
Ba	permit. Departr Import		I Can Orten	MO1386 RO	ckville,	Inc.	300 West Mo	ntiomery A	neral Home/ Jenue
68760,	The law requires that the death certificate be executed as the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Medical Examiner	cause. Enter Undertying Cause (Disease or riginy that initiated events resulting in death) Last C Due to (or as d	a consequence of:	_		ith recent infortu		Approximate Interval Batween Onset and Death
P.O. Box	that the death c ed by the attend detached for us	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3 time of death 5	Ectopic pregnanc Other (specify) _	1		23d. Date of deli	Day Year
Records, 1	w requires that been signed should be de	by	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
_		Completed						y prior to o death? 2 No 1 ☐ Yes	opsy findings available ompletion of cause of 2M No
Vital	or Attending Physicien; after death. Director; After this certifici in by the funeral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 22 No Hospital: Alippatie	ent 2 ER/Outpatien	. 3CI DO4 Ott	her	of Death (Check only on		
	Phys or this aral di		27. Manner of eath 28a. Date of Inju	ry 28b. Time of	I 3L DOA	4 🗀 IVUI	rsing Home 5 🗋 Reside	ow injury occurred	iry)
Division	Attending F r death. sctor; After by the funera	tloi	Natural 5 ☐ Pending (Month, Da) 2 ☐ Accident investigation	y Year) Injury		irk?]Yes 2.∐1	No		
Vis	Attendii ir death. ector; A by the fu	iffe	3 Suicide 6 Could not be determined 28e. Place of Inj	ury - At home, farm, str	eet, factory, office			reet and Number or Ru	ral Route Number,
	s after al Direct	Certification:	4 Homicide Statistics building, et	c. (Specify)			City or Town	n, State)	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director; completely filled in by the	Medical (29a. Certifier (Check only one) Certifying Physicien: To the best 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	occurred at the tivestigation, in my o	ime, date and opinion, deat	d place, and due to the ca th occurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
, d	With To Com	1	286. Signature and wife of early filer Ray m	m) mo	29c. Licens	39 /		9d. Date signed (Month	. Day, Year)
Y	Y) (30. Name and address of person why completed cause of d				-		
			Robert L. Kaufmann, M.D. 30				rick, Maryl	and 21701	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature	Coarl				
DI	negisti		JUN 1 5 ZUJO	DEBENE JO	1				

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			1 - State of Ma		artment of Health		lygien Reg. N	611115	19928		
Ī	Physici /Medic		Decedent's Name (First, Middle, Last) EDWARD ROBERT LEWANDO	OWSKI		2. Date o Month JUNE	Death	ay Year	3. Time of Death 11:10 Ам		
	Examir		4a. Facility Name (If not institution, give street and number) CHESAPEAKE HOSPICE HOUSE	4b. City, Town, or Location LINTHICL	JM	4c. County of Death ANNE ARUNDEL					
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Memtal Hygiene. If Health and Memtal Hygiene and Health	To Be Completed by Funeral Director	5. Social Security Number 6. Sex 7. Agr 217-14-3845 2 F Usual Residence of Decedent	e (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of (Month) MARC	Day, Yea	9. Birthp Cour 1923 PEN	9. Birthplace (State or Foreign Country) 923 PENNSYLVANIA		
, Maryland 21215-0036			10a. State 10b. County N/A	10c. City, Town or Lo				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No		
			10e. Street and Number 459 PEMBROOK BLVD.	10f. Zip Code	21224	_	g. Citizen of What Country? NITED STATES				
			11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Armed Forces? 1 ☑ Yes, Give Year or Dates:	io	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☐ No Specify.		No-	14. Race - Americ Black, White, Specify: WH			
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	st of working		16b. Kind of Business/Industry PRESS COMPANY					
			17. Father's Name (First, Middle, Last) STANLEY LEWANDOWSKI			er's Name (First, Mic CY WARCZIN		n Sumame)			
			19a. Informant's Name/Relationship (Type, Print) THERESA REMEIKIS/SISTER	459 F	ng Address (Street and Numb PEMBROOK BLVD.	BALTIMOR	mber, City E, MA	o <i>r Town, State, Zip</i> RYLAND 21	Code) 224		
altimore,	Page nent o int: If iry or		20a. Method of Disposition 1 □ Burial 2 ☼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		CORY ORY	Date 6/14/05	LA	Location - City or To UREL, MAR	YLAND		
Ball	permit. Departn Importe any inju		21. Signature of Feneral Service License		2. Name and Address of Facili 6224 EASTERN	AVE., BAL	ΓIMOR				
	Pnysician /Medical Examiner	10	Approximate shock, or heart failure. List that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List that caused the death one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence or sequence or sequence) Sequentially list conditions, b.								
98/60,	death certificate be executed e attending physician and id for use as the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cause). Due to (or as a cause). Due to (or as a cause). Due to (or as a cause).								
O. Box	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funderel Director After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome to 1 □ Live birth to 1 □ Li			23d. Date of delivery Month Day Year					
Division of Vital Records, P.		by	Part II. Other significant conditions contributing to death bu	1	obacco use contribute to the cause of death? Yes 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \)						
		Medical Certification: To Be Completed	OF Man and referred to madical		pe 1 □ Ye	prior to completion of cause of death? s 20 No 1 Yes 20 No					
			25. Was case referred to medical examiner? 1 Yes 2 No		th (Check only one) Check only one) Other (Specify) 28d. Describe how injury occurred						
DIX			4 Homicide building, etc			City or	Town, Stat				
			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Z 2 2 8	7	29b. Signature and title of certifier		29c. License number)	120	ate signed (Month, E	7005		
	7		30. Name and address of person who completed cause of de	305 Ho	scoral DI	1ve, 6/e,	oPhr	rie, sid.	106/		
	Sta Registr	-	3Y. Date filed (Month, Day, Year) JUN 1 5 2005	r's Signature				-			

Baltimore, Maryland 21215-0036

Funeral

Director

or Items 23a

other traumatic avant, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other treumatic avant, the Magnetic avant, the Magnetic avant, the Magnetic avant, the Magnetic avant, the Magnetic avant, the Magnetic avant and available avants. **Physician** /Medical **Examiner** Examiner burial-transit attending physician Box 68760 Physician/Medical P.O. | ģ death. To the Hospital within 24 hours a To the Funeral D

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 10, 2005 **Physician** 1:25A MARY RITA MORGAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. Month, Day, Hours Min. (Month, Day, August 7, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2∏F Yrs. 84 Illinois 095**-1**4-6746 Usual Residence of Decedent 10c, City, Town or Location 10a, State 10h Count 10d. Inside City Limits 1 ☐ Yes Z No Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 615 Chestnut Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes X No Specify: White δ XX Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret Cecelia Sullivan Charles Stewart Beasley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son Stephen H Morgan 10600 Lakespring Way Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1) Surial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 6/13/05 Lutherville, Maryland Donation 5 Other (Specify) nature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio myopathy Immediate Cause (Final Schome HEAUS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 112 Yes 2 □ No 3 □ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Sther (Specify) NOT PLC 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ctifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check or one) and manner stated 29d. Date signed (Month, Day, Year) 58303 Ni Charles St Powsm, and 21204 31. Date filed (Month, Day, Year) State JUN 1 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 10e per fh 8844 6-20-05 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** RANCES TUNE MILLER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE OWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Min. Jun E 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs_last birthday) **Funeral** Months 1 ☐ M 2 KF 219-18-102 Yrs. Director AROLINA Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Yes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 2122 WHEELER 45A. or items 23a death Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2M No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, Ite Media once. Elementary/Secondary (0-12) College (1-4or 5+) GHAGRADE MAKER HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WILLIAMS ပ္ UGENE GOODMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 2116 WEST LEXING FON ST. BALTO, MD. 21223 STELLA TRUST Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 Removal from State 06-18-05 GLEN BURNIE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee BROWN TR. FUNERAL HOME BALTO. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Cancer Physician DOV S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably Unknown Completed 24a. Was an autopsy performed?
1 Yes 25000 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS Pice 1 Yes Certification; To 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending ours efter death. neral Director; A filled in by the fo 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Signature and trip of certifier June 12 2005 58303 completed cause of death (Item 23a) (Type, Print) orles St Towson, MD 21204 MON 31. Date filed (Month, Day, Year) 32. Registrar's annature State JUN 1 5 2005 Registrar

FRANCES

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** ICKENNEY 6:00 AM JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA COURT BALTIMORE BAKBURY If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) DEC . 24, 1942 MARYLAND 5. Social Security Number Funeral Months 218-58-393 1 ☐ M 2 🗷 F 60 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No MARYLAND CITY Director ALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ŏ 2121 1675 BAKBURY COURT Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 No ō 1□Yes 2XNo Specify: Specify: BLACK 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME GITH GRADE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ont of Health and Mental Hit: If Itam 27 Is markad oth y or othar traumatic evan 1 and 2 should be MCKENNEY T3ERTHA WALKER LEDN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARSH (DAUGHTER) 1602 SPRAY CT, APT & BALTIMORE, MD 21217 JUANITA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. KING MEMORIAL PARK D6-14-2005 WOODLAWN, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 505 EPH H. BROWN JR. FUNERAL 21. Signature of Funeral Service Licenses Muam NU 2140 N. FULTON AVE, BALTIMORE, M.D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Physician silascu /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit Due to (or as a conse Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☑No 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy rmed? 2.2 No Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Thomicide 29a. Certifier

To the Hospital or Attending Physician: within 24 hours after To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier m ·1) 46596 layative 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) Saratiga street HC 1501 aya, 31. Date filed (Month, Day, Year) 32. Registrar's Simature State

Registrar

DHMH 17 Rev 1/2001

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21223

		1	For State Ragistrar	State o	of Marylan		artmen tificate			and M		giene Rag. No 2	005	190	332
Phys	ician	_	1. Decedent's Name (First, Middle, Last) DELOYN R. MILLER 2. Date of Death Month Day MAY 29, 2005								Year	3. Time of 9:55			
/Me Exan	dical niner		a. Facility Name (If not institution,		m <i>ber</i>)		4b. City,	Town, or	Location o	of Death	11/(1 25		4c. County of Death		
			1046 DUAL PL				lá I la da s		ERST(0.7.4.4.0	WASHINGTON			Envisor
Funer Directo			Social Security Number	6.Sex 1∭2 (M 2 □ F	7. Age (<i>I</i> n <i>yr</i> s. <i>I</i>	last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt (Month, Pa) 2/26/1	913	OH I	iplace (State c intry)	r Foreign
D		U	sual Residence of Decedent 0a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside Ci	ity Limits
Maryle I-f sho	Į		MD WASHI	NGTON		HAGER		Į						1 🖺 Yes	2 XN0
ith the or 28a	Director	1	10e. Street and Number 10f. Zip Code 10g. 0							•	n of What Co	intry?			
s 23a	ra		1046 DUAL PL		edent Ever in U.	C 13 1	Nas Decer		L740	ain? (Spe	acify Yes or No		USA Race - Amer	ican Indian.	
036 urs after de el', or Item	by Funeral		Marital Status Never Married 2 Marrie Widowed 4 □ Divorced	Armed F	orces?	i	f Yes, spec		Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		Black, White		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland popartment of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Evercit at mark to ricitify of	Completed	_	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WELDER							16b. Kind	o. Kind of Business/Industry COMMERCIAL				
Maryland 2: nd 2 should be filed v lith and Mental Hygie 27 Is marked other? r traumatic event, II.	To Be Co	3 1	8 7. Father's Name (First, Middle, L WILLIAM E. M				METO	- K			<i>(First, Middle,</i>	Maiden St		NOTAL_	
Mary 2 shou and N			19a. Informant's Name/Relationsh HELEN MILLER	nip (Type, Print)							al Route Numbe GERSTOW			ip Code)	
re, N s 1 and Health tem 27		_	0a. Method of Disposition			Place of Dispo	sition (Nan	ne of			Date		ation - City or	Town, State	
Baltimore, Dermit. Pages 1 a Department of Hec Importent: If item eny injury or othe			1 XeXirial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc		State	VERVIEW	CEMETE	RY		JUNE 2005			.IAMSPORT		
Balt permit. Departi Import	once.		21. Signature of Funeral Service L	m. BI	rown)		MAK	<u>i TN2R0i</u>	Klu, W	D. BOX 82 V 2540 2		W. KING		
Physicia	m	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)									Approximate Interval Between Onset and Death				
/Medic Examine	_		resulting in death) Due to (or as a consequence of):					1/10/0					10-20105		
8760, rate be executed hysician and the burial-transit	Fyaminer		f any, leading to immediate ausse. Enter Underlying Cause (Disease or injury that initiated events esulting in death) Last	c	o (or as a conseq										
ecords, P.O. Box 68 law requires that the death certificat as been signed by the attending phy 2 should be detached for use as the	lan/Mel	3	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23	id. Date of delivery Month Day Year			
rds, P quires that n signed b	ì	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ ☒ nkno				
age h	2	noil bien									24a. Was autop perfo 1 ☐ Yes	an osy ormed? 2XXIVo	prior to death?	topsy findings completion of c	available cause of
of Vital Physicien: T	á	ם ו	25. Was case referred to medical examiner? 1												
of Phys g Phys er this eral dir	F	- 1	CO. Detection CO. Time of Co. January Co. Describe by							me 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred					
Division of Vital of Attending Physicien: T attendenth Director: After this certificat din by the funeral director, p	1	Call									treet and Number or Rural Route Number, n, State)				
Hospite 4 hours Funerel ely filled	0	edical ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									s)			
To the within 2 To the Complet	2		29b. Signature and title of certifie			MD		c. Licens	6413			29d. Date	signed (Mont	h, Day, Year)	
61			30. Name and address of person SANJAY SAXENA		use of death (Iter	DD	MITIT	AMSF	ORT,	MD.	21795				
	State istra	-	31. Date filed (Month, Day, Year) JUN 1	5 2005 32.	Registrar's Signa	ature /	pode	1							

			For State Registrar	State of Maryland		artment of H rtificate of L		Mental Hy	/giene Reg. No.		
	Physic: /Medi		1. Decedent's Name (First, Middle, L JOHH R	•	MA	GUIRE	5R	2. Date of De Month 06		2005	3. Time of Death. 4:30 AM
	Examir		4a. Facility Name (If not institution, grant privilege) 7407 Sparr Drive	e		4b. City, Town, or Kingsv			4c.	County of Death Baltimor	·e
	Funeral Director		5. Social Security Number 6. 219–10–1891 Usual Residence of Decedent	Sex 7. Age (<i>In yrs. last</i> 1	Yrs.	If Under 1 Year Months Days	Hours Mir		rth ay, Yea <i>r)</i> 1926	Coun	lace (State or Foreign itry) yland
	with the Maryland a or 28a-1 show	ctor	10a. State 10b. County MD Balti	more Kine	own or Lo gsvil					1	0d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23e or 28	ai Director	10e. Street and Number 7407 Sparr Dri			10f. Zip Code 21087				zen of What Coun	try?
36	after dea	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes. Give		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0- 1	4. Race - Americ Black, White,	
21215-0036	within 72 hours ene. than "natural"	Completed b	15. Decedent's 8 (Specify only highest g.	Year or Dates: WW II Education rade completed) College (1-4or 5+)	6a. Deced (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired,	ition Juring most of w	orking	16b. Kin	Whi	
	is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	Be	8 17. Father's Name (First, Middle, Las		Mech	anic	18. Mother's Na	ame (First, Middle			ransmissio
Maryland	d 2 should th and Men 7 is marke traumatic	To	John Raymond Mar 19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street a	nd Number or F		er, City or		
Baltimore,	ages 1 and ent of Healing: If item 2		Shiela M. Barrho 20a. Method of Disposition 1 X Burial 2 Cremation 3 1 4 Donation 5 Other (Spec	☐Removal from State	of Dispo etery, crer	Sparr Dri sition (Name of natory or other place Mem. Park	9)	Date	20c. Loc	ryland cation-City or To imore, M	
Baltii	permit. Pages Department of Pimportant: If ite any injury or of once.		21. Signature of Funeral Service Lice		22		s of Facility ${f E}_ullet$	F. Lass	sahn I	Funeral	Home, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		o not ent		, such as cardia	c or respiratory a			Approximate Interval Between Onset and Death 4 mon Tit-
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	b. Due to (or as a consequent	ce of):						
68760,	icate be executed physician and s the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consequence d.	ce of):						
О. Вох	requires that the death certific een signed by the attending pl hould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dec 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions PULMONAN				n in Part I.		tobacco us		e cause of death? ably 4 Unknown
al Reco	The law ate has b page 2 sl	Completed						24a. Was auto perfo 1 \(\text{Yes} \)		prior to con death?	osy findings available inpletion of cause of
of Vita	g Physician: The er this certificate eral director, pag	n; To Be	25. Was case referred to medical examiner? 1 Yes 27 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/ 28a. Date of Injury (Month, Day Year) 28I	o. Time of	t 3 DOA Othe	r: 4 🗆 Nursing	ath <i>(Check only only only only only only only only</i>	dence 6	Other (Specify)
Division of Vital Records,	or Attending Fafter death. Director: After in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not lead to determine	on Open Diagram (Injury A) home	Injury , farm, str	M 1 1 Y	? 'es 2 □ No	28f. Location (City or To		Number or Rural	Route Number,
_	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
	within To the comp	ž V	29b. Signature and alle of entirior	w m	Ø	29c. License	77-8	7	_	signed (Month, L	Day, Year) 2005
1	Sta	.0	A /	o completed cause of death (Item 23:	LL	och R	AUEM				2 E M P 2,23
	Registr	-	JUN 15	2005 32. Ragistrar's Signature	A	mente					

RAYMOND Magicine

		_	For State Registrar	State of M	aryland .		artmen rtificate			ınd Me	ental Hy	giene Reg. No	0 10 0		199	34
	Discosioni		1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	eath Da	IV.	Year	3. Time of Di	eath "
	Physici /Medic		BLAKE	ELLSWOR'	ГН	MET	Z				JUNE	12	2005		0017	М
	Examin		4a. Facility Name (If not institution,	- 1 1 2		1			Location o				. County o			
			SACRED H	EART HO	Spita	h			ERI				1 LLE			
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last 86	t birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D. July 2	av. Yearl)	Cour	lace (State or F itry)	oreign
	Director		215-12-2346 Usual Residence of Decedent			113.					July 2		1918	Mary	Land	
	land		10a. State 10b. County		10c. City, T	own or Lo	cation							1	0d. Inside City	Limits
	Many 1 sh	ō	MD A11	egany	1	Frost	hure								1 X Yes 2	. □ No
	28a	Je C	10e. Street and Number	-8			10f. Zip	Code				10g. Ci	tizen of W	hat Cour	ntry?	
	3a o	D	206 Maple P	lace				2153	32		,		USA			
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examinat reust be riotified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Deced			gin? (Spec	cify Yes or No Rican, etc.)	0-	14. Race		an Indian,	
9	or ite	Ē	1 Never Married 2 Marri			-	1 Ū Yes		Specify:	, ruento i	noan, etc.)		Specify:			
21215-0036	ours Fai',	d by	3 X Widowed 4 □ Divorced	Year or Dates:			10163	222110	Specify.				Specify.	Wh	ite	
5-	72 h 'natu	Completed	15. Decedent (Specify only highes		1	(Give	dent's Usua kind of wo	rk done d	durina most	t of workin	g	16b. K	Kind of Bus	iness/In	dustry	
121	vithin ne. han	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)		dy re		•			A	a Pa	der C	han	
	filed withi Hygiene. other than ent, the M		17. Father's Name (First, Middle, i	ast)			dy le	ралі		r's Name	(First, Middle		O Bo		пор	
anc	ntal hed ol	Be	Howard Parson	•							lle Sw			,		
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It a Medical Examination is to notified at	10	19a. Informant's Name/Relationsh			19b Maili	ng Address	(Street a			Route Numb			State. Zir.	Code)	
Z	d 2 sho th and ?7 is mu traum		Ladona G. Dick		-1									e i	,	
Ó,	1 and Health Iem 27 other tr	11.0	20a. Method of Disposition	er/Daughter	20b. Plac	e of Dispo	Map 1 osition (Nar.	ne of			tburg.		ocation - C		own, State	
10	Pages nent of int: if it		1 Burial 2 Cremation			-	matory`or o Mamar		Garde	Ji	une 16		T -37-3	1	WD.	
Baltimore,		1	* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I	- 1	Resti				s of Facilit		2005 ith Fu		LaVal		MD	
Ba	permit. Departr imports any inje		Bair	L. Suit	T					, Dill	Keys			me 2672	6	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death.	Do not en									Approximate Interval Betwe	
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. COV Due to (or as b. Due to (or as c.	7 G Q sa consequents sa consequen	nce of):	VQ	H	EAI	27	Fail	ve			Opset and De	ath 11°C
8760,	certificate be executed rding physician and use as the burial-transit	ai Ex	resulting in death) Last	Due to (or as	a consequen	nce of):										
687	ficate physis the	edic		d												
.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3[⊒Ectopic pr ⊒ Other <i>(sp</i>						23d. Date Mon		ery Day Ye	ar
rds, P	law requires that the death as been signed by the atter 2 should be detached for u	þ	Part II. Other significant condition	ns contributing to death I	out not resulting	ng in the u	inderlying c	ause give	en in Part I.			tobacco Yes 2		bute to ti 3 🗌 Prob	ne cause of dea	
Records,	e - e	Completed									24a. Was auto perf 1 Yes			ere autorior to co eath?	psy findings av mpletion of cau	ailable ise of
Vital	ifcian: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	/				
f V	Physician: this certific ral director,	10 6	1 Yes 25 No	Hospital: 1 ☐ Inpati	ent 2 ER	VOutpatie	nt 3 DC	OA Othe	er: 4 🗋 Nu	rsing Hom	ne 5□Res	idence	6 Othe	r (Specif	y)	
n of	ng Ph ter th		27. Manner of Death Natural 5 Pendin	28a. Date of Inj (Month, Da	ury 28 ay Year)	Bb. Time o	of 2	8c. Injun Worl	y at k?	2	8d. Describe	how inju	ury occurre	d		
ioi	Attending r death. sctor: After y the fune	atle	2 Accident investig	ation	1/4		M	10	Yes 2 □	No						
Division	or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of it	ijury - At home tc. (Specify)	e, farm, st	reet, factory	y, office		2	8f. Location City or To			r or Rura	al Route Numbe	9ľ.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the best Examiner: On the basis of and manner s	of examination	edge, deat n and/or in	th occurred evestigation	at the tin	ne, date an pinion, dea	d place, a th occurre	nd due to the	cause(s	s) and man	ner as s nd due t	tated. the cause(s)	
	To the Vithin 2 To the complet	×	206. Signature and title of certifie	$\leq \wedge \wedge$		^	290	c. License	e number			29d. Da	ate signed	(Month,	Day, Year)	
) ,	1 10	1	トレント	VVI	M		\mathcal{L}	550	475	56		JUN	NE NE	20	05	
&	\mathcal{V}		30. Name and address of person	who completed cause of	death (Item 2)	3a) (Type,	Print)	/	1 100	- jod	1 0000 1 2 20					
	Str	ate	31. Date filed (Month, Day, Year)		ウル レー trar's Signatur	re	řem D	38 (Q)	10, 10	42	1) 12					
	Regist		JUN 15	2005	trar's Signatur	So	of									

Physician / Medical Examiner of Hearing and Medical Examiner of Hearing and Medical Examiner of Hearing Ex	5/8-36-1990 sual Residence of Decedent ia. State 10b. County Maryland N ie. Street and Number 11 West 20th Street . Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last)	Ollie G street and number) F BACTI A Sex 7. Age (In y 10c. 112. Was Decedent Ever in Armed Forces? 1	rrs. last birthday) 77 Yrs. City, Town or Lo	4b. City, Town, B4U If Under 1 Year Months Days cation B 10f. Zip Code Was Decedent of If Yes, specify Cut 1 Yes 2 No dent's Usual Occur kind of work done DO NOT use retire	Baltimore 21218 Hispanic Origin? (ban, Mexican, Pue o Specity:	Specify Yes or Norto Rican, etc.)	Day Year Year Year) 9. E 1927	path N/A Sithplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 Yes 2 No Country? S.A. merican Indian,
Medical Examiner of ream and Mental Hygene. Separation of ream and Mental Hygene. Important: If itam 27 is marked other than "natural; or Itams 23a or 28a-1 show injury or other traumatic avant, Ita Medical Evanture must be notified at any injury or other traumatic avant, Ita Medical Evanture must be notified at any injury or other traumatic avant, Ita Medical Evanture must be notified at any injury or other traumatic avant, Ita Medical Evanture must be notified at any injury or other traumatic avant, Ita Medical Evanture must be not injury or other traumatic avant and injury or other avant and injury or ot	Social Security Number 578-36-1990 Sual Residence of Decedent Ina. State 10b. County Maryland Ina. Street and Number 11 West 20th Street Marital Status 1 Never Married 15. Decedent's Ed (Specify only highest grant part of the street gra	a street and number) BACTI YA 10c. 11c. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Itucation College (1-4or 5+) Crews	rrs. last birthday) 77 City, Town or Lo	4b. City, Town, B4U If Under 1 Year Months Days cation B 10f. Zip Code Was Decedent of If Yes, specify Cut 1 Yes 2 No dent's Usual Occur kind of work done DO NOT use retire	If Under 24 Hr. Hours Mir Baltimore 21218 Hispanic Origin? (ban, Mexican, Pue o Specity:	Specify Yes or Norto Rican, etc.)	Year) 1927 9. E 1927 14. Race - Ar Black, W	path N/A Siminplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 Yes 2 No Country? S.A. merican Indian, hite, etc.
Department of really and wental rygence. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic avent, the Medical Examination any injury or other traumatic avent, the Medical Examination any injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent, the Medical Examination and injury or other traumatic avent injury or other	Social Security Number 578-36-1990 Sual Residence of Decedent Ina. State 10b. County Maryland Ina. Street and Number 11 West 20th Street Marital Status 1 Never Married 15. Decedent's Ed (Specify only highest grant part of the street gra	PACTOR AND TO THE PROPERTY OF	rrs. last birthday) 77 Yrs. City, Town or Lo	B4L If Under 1 Year Months Days Decation B 10f. Zip Code Was Decedent of If Yes, specify Cut 1 Yes 2 No dent's Usual Occur kind of work done DO NOT use retire	If Under 24 Hr. Hours Mir Baltimore 21218 Hispanic Origin? (ban, Mexican, Pue o Specity:	Specify Yes or Norto Rican, etc.)	Year) 1927 9. E 1927 Og. Citizen of What U. 14. Race - Ar Black, W	N/A Sirthplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 Yes 2 No Country? S.A. merican Indian, hite, etc.
Department of ream and Mental Hygiene. Important: If itam 27 is marked other than "natural, or itams 23a or 28a-f show interest in the profile of the profi	Social Security Number 578-36-1990 sual Residence of Decedent a. State 10b. County Maryland N. be. Street and Number 11 West 20th Street Marital Status 1 Never Married 3 Widowed 4 Divorced (Specify only highest grade) Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last) Booker 9a. Informant's Name/Relationship (7) Rhoda Ford Daughter 1a. Method of Disposition	7. Age (In y	rrs. last birthday) 77 Yrs. City, Town or Lo	If Under 1 Year Months Days cation Individual Occur kind of work done DO NOT use retires	Baltimore 21218 Hispanic Origin? (ban, Mexican, Pue o Specify:	Nov 26,	Dg. Citizen of What U. 14. Race - Ar Black, W	Sirthplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 1 Yes 2 No Country? S.A. herican Indian, hite, etc.
Indicated and when a rygene. Indica	578-36-1990 sual Residence of Decedent a. State 10b. County Maryland N. be. Street and Number 11 West 20th Street . Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grade) Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last) Booker Ba. Informant's Name/Relationship (7) Rhoda Ford Daughter 12. Method of Disposition	10c. 12. Was Decedent Ever in Armed Forces? 1	77 Yrs. City, Town or Lo	Months Days cation B 10f. Zip Code Was Decedent of If Yes, specify Cut 1 Yes 2 No dent's Usual Occur kind of work done DO NOT use retire	Baltimore 21218 Hispanic Origin? (ban, Mexican, Pue	Nov 26,	Dg. Citizen of What U. 14. Race - Ar Black, W	Virginia 10d. Inside City Limits 1 Yes 2 No Country? S.A. merican Indian, hite, etc.
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ilical Examiner	nmediate Cause (Final issease or condition esulting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events isulting in death) Last	b. Due to (or as a condition of the cond	sequence of):					Onset and Death
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27.	7. Manner of eath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wo	ury at ork? Yes 2 No	28d. Describe ho	w injury occurred	
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2	9a. Certifier (Check only one) Certifying Physical Example 1 Medicel Example 1	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or in	h occurred at the t vestigation, in my	time, date and place opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
29 ×	9b. Signature and title of certifier			29c. Licen	ise number	29	d. Date signed (Mo	nth, Day, Year)
	D. Name and address of person who	completed sauce of death	D	RES	5-666	,	JUNE 9	2005
State 31	BATHERIM	E Manual Cause of death (ME 1		STNAT H	OSP MAL	OF BA	THIRE

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	Funeral Director		5. Social Security Number 6. Sex, 7. Age (In yr	enter s. last birthday) 2 Yrs.		1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Dec. 16	Year) 1952	9. Birthp Cour	olace (State or Foreign Md.
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	nd 2 state are		19a. Informant's Name/Relationship (Type, Print) Ruby Monroe Wife		-				al Route Number, or, Md. 2124		State, Zip	Code)
Baltimore,	Pages ment of ant: If it ury or o		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	Place of Dispo cemetery, cre Sarrison Fo	rest Ve	ther place erans	Cemete	ery (Date 2 06/21/05	20c. Location - Owi	City or To	
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.O. Box 68	the death certificate t the attending physiched for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time or 9 □ Unknown	etal death 3	□Ectopic p						te of delive	ery Day Year
<u>α</u>	uires that the de signed by the a id be detached i		Part II. Other significant conditions contributing to death but not r End State Renal Disease	esulting in the u	inderlying o	ause give	en in Part I.		23e. Did tob	V		he cause of death?
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Vita	Physician: The lav this certificate has ral director, page 2	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 🗍 D(Othe	261		n (Check only one		ner (Specif	(v)
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	To the Hospital within 24 hours and the Funeral completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my k Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, th occurr	and due to the ca ed at the time, da	use(s) and mate and place,	anner as si and due to	tated. the cause(s)
)	To the within 2 To tha Complet	W	29b. Signature and title of certifier Port By But	~ MD.		License	834			Od. Date signe		
	4		30. Name and address of person wholdompleted cause of death (II Rubert Bryon Butler 22 31. Date filed (Month, Day, Year) 32. Registrars Sig	South		le S	t., E	Balhi	nave, Mo	yland	212	.01
	Sta Registi	rar	JUN 1 5 2005		Also .							
DH	IMH 17 Rev 1/2	001		ORIGINA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9 9:30 P M Hilda С. McDonagh June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 ☐ XF Director 213-34-8838 70 19,1934 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7A Brook Farm Court U.S.A. 21128 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) es 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other then 12 Homemaker Own Home and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Snack Lillian Michels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Leo C. McDonagh, Jr.</u> 7A Brook Farm Court other t Husband Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 0 permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 6-13-2005 Sykesville, Maryland re of Purraral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Anyotophic Cateral Years disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 henths?

1 Yes 2 Yo 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 4☐Pregnant at time of death P.O. detached 9 Unknown 9 Unknown / Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Anatural 2 Accident 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Division or Attending 5 Pending investigation after death. in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2 To the

Registrar DHMH 17 Rev 1/2001

State

15

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Silver & Apolis

AARON Charles MD 6601 N Charles St. Towson MD 21204

29c. License number

D58303

29d. Date signed (Month, Day, Year)

			1 - For State Registrar		ryland / Dep Ce	artment		and M	lental Hyg		0 0 5	19938
	Physic /Medi		1. Decedent's Name (First, Middle, La.	Ghee					2. Date of Deat Month	h Day	Year 2005	3. Time of Death
	Exami		5. Social Security Number 6. S	edical (interpretation)	(In yrs. last birthday	B G		r 24 Hrs.	8. Date of Birth	4c. Cou	nty of Death	lace (State or Foreign
	Director		223-36-8942 Usual Residence of Decedent 10a. State 10b. County	ØM 2□F 7	Yrs. 10c. City, Town or L		Days Hours	Min.	(Month, Day, May 9,1		Vir	ginia Od. Inside City Limits
	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or Itams 23a or 28a-f show od other than "natural", or Itams 23a or 28a-f show event, I're Madical Exactive roust by multibed at	Funeral Director	Maryland Bal 10e. Street and Number 1607 Gray Place	timore		Du 10f. Zip C	ındalk ode 212	22	10	-	of What Count	1 ☐ Yes 2 🔯 No try?
36	urs after death II', or Itams 23 Ye i iber is us	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1X Yes 2 N If Yes, Give Year or Dates:	0	Was Deceder If Yes, specify			ecify Yes or No- Rican, etc.)	14. F	Race - America Black, White, e	an Indian,
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	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (1 Mr. Bradley T. Mcd 20a. Method of Disposition		her) 512	Jacks	Creek R	oad	Ravens,	VA	vn, State, Zip (24639 n - City or Tov	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		1 Burial 2 Cremation 3 C 4 Donation 5 Nother (Specify 21. Sign after of Juneal Service Li	Entombren	Holly I	matory or other Hill Me 2. Name and A	m. Gdns	. 6/1		Mid	dle Riv	ver, MD
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68760,	death certificate be executed e attending physician and of for use as the burial-transit	ical	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
P.O. Box	that the death certifical ed by the attending phydelached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome or 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	⊒Ectopic pregr ⊒ Other <i>(specit</i>					Date of delivery Month D	y Day Year
	v requires baen sign should be	by	Part II. Other significant conditions of	ntributing to death but	not resulting in the u	nderlying caus	e given in Part I.		1 🗆 Yes	2 □ No	3 📑 Frobat	cause of death?
	ysiclan: The law is certificate has b director, page 2 st	Be Completed	25. Was case referred to medical examiner?				26. Place	of Death	24a. Was an autopsy perform 1 Yes 2 (Check only one	ed?	prior to comp death? 1 Yes 2	sy findings available pletion of cause of
of	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	ertification; To	1 Yes 2	1 Hopatient 28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c.	Injury at Work? 1 ☐ Yes 2 ☐ I	No 2	ne 5 □ Residen 8d. Describe how	injury occi	urred	
ā	Hospital or Al 24 hours after o Funeral Direc stely filled in by	O	4 Homicide determined 29a. Certifier 1 Certifying Phy	building, etc.	my knowledge deat	a necurred at the	na tima data an	d place, as	8f. Location (Stre City or Town,	State)		
	To the Ho within 24 r To the Fu completely	Medical	(Check only one) 2 Medical Examination Medical	ner: On the basis of e and manner state	xamination and/or in	vestigation, in i	my opinion, deal	th occurred	d at the time, dat	e and place	ed (Month, Da	he cause(s)
0.	سراد	7	30. Nam and address of person who co	6 4	th (Item 23a) (Type,		1107:				0-200	2
	Sta Registr		Jared Borkowitz B 31. Date filed (Month, Day, Year)	32. Registrar	s Signature	k./ 10		breeze	St Br	hmy	MD 2	.1201
DHN	MH 17 Rev 1/20	7	JUN	1 5 2065	Signature	· And	de					

ORIGINAL

			For State - State Registrar	te of Maryland / Depa	artment of Health and trificate of Death	d Mental Hygier	C) m
	Physici		1. Decedent's Name (First, Middle, Last) David S. Nagle			2. Date of Death	Day Year 3. Time of Death 9
	/Medic Examir Funeral	ier	4a. Facility Name (If not institution, give street a November Arundel 5. Social Security Number 6. Sex	HOSPITAL 7. Age (In yrs. last birthday)	4b. City, Town, or Location of De GEN But If Under 1 Year If Under 24 F Months Days Hours M	rnu i	4c. County of Death Anne Arundel 9. Birthplace (State or Foreign
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	ath with the Maryla 23a or 28e-f showns to be second	Funeral Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	death w	lal	7748 Williams Street		21122		USA
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	d 2 sho Ith and I	. 5	19a. Informant's Name/Relationship (Type, Pri Connie Nagle (S		ng Address <i>(Street and Number or</i> 8 Williams Stree		
Se P	Pages 1 and 2 should hent of Health and Men nt: If item 27 is marke iry or other treumatic		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Remova	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	ne 15	Location - City or Town, State
Baltimore,	permit. Page Department of Importent: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature Hunera Service Lice see		ematory Inc. Name and Address of Facility 3111 Mountain I	Stallings	timore, Maryland Funeral Home, P.A. na, MD 21122
	ř.		23a. Part f. Enter the disease, or complications shock, or heart failure. List only one calls	nat caused the death. Do not ent e on each line.	er the mode of dying, such as card	diac or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	e Chronic o	bshiedive	des kre
	Examiner.	ē		Oue to (or as a consequence of):	tue twe tu	ing diseas	2
8760,	ate be executed hysician and the burial-transit	cal Examiner	cause. Enter Underlying Cause (Discuss of Figury) that initiated events c	Due to (or 4s a consequence of):		M	
.O. Box 68	ne death certific the attending pl thed for use as t	Physician/Medl	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	w requires that the been signed by should be detact	by	Part II. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Records,		Completed				24a. Was an autopsy performed 1 Yes 2 X	
\ ita	ician: T certifical rector, p	Be	25. Was case referred to medical examiner?	1:	0.1	Death (Check only one)	
10	ding Phys	on: To	T Tes 200 No	" 1 ∰ Inpatient 2 ☐ ER/Outpatier Date of Injury 28b. Time of (Month, Day Year) Injury	11 30 000	g Home 5 Residence 28d. Describe how in	
Division	or Attenditer deatl	Certification:	2 Accident investigation	. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	e Hospital 124 hours a e Funeral i letely filled	edical Ce	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death			
	To the within 2 To the complet	Med	one) an 29b. Signature and title of certifier	d manner stated.	29c. License number	29d. [Date signed (Month, Day, Year)
	C = 5 + 5		▶ Aule	W.)	146596	6	11/05
1)			ed cause of death (Item 23a) (Type,	Print) Arundel	L Hrsfil	al Glenburia
7	Sta Regist	0.1	31. Date filed (Month, Day, Year) 1 5 2	OUS Registry's Signature	Sporte	ŧ	Û

			For State Registrar	State of Man	•	artment of I			giene Reg. No. 2	n c	10010
			Decedent's Name (First, Middle, Last,		0	•	•	2. Date of Dea	ath		. Time of Death
	Physici /Medic		WARREN	NRONE	YER1	EE		JUNE		Year 005	1110 M
	Examin		4a. Facility Name (If not institution, give	street and number)	. /	4b. City, Town	or Location of Deat		4c. County of	of Death	
			University Special	y Huspita	<u> </u>		ACTIMOR				
	Funeral		5. Social Security Nilmber 6. Se	xy 7. Age (li	n yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da APKIL	y, Year)	9. Birthplace	(State or Foreign
	Director		Usual Residence of Decedent		0			PIPKIL 1	4,1941	FLOR	IVH
	yland yland		10a. State 10b. County	10	C. City, Town or Lo					10d.	Inside City Limit
	Mar.	ici	$M_{\mathcal{D}}$			PHO	57V/X				1 ☐ Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural; or Items 23a or 28a-f ahow or other traumatic event, Ite Medical Examinar must be multired at	Funeral Director	10e. Street and Number 8 OVERSHOT	Ct.		10f. Zip Code	21131		10g. Citizen of W	hat Country?	
	ms 2	nere	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No	- 14. Race	- American I	ndian,
9	or Its	교	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 No		o moun, etc.,	Specify:	LIA	CK
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						/	
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Bus	siness/indust	ry
12	withiu ene. than	Ę	Elementary/Secondary (0-12)	College 1-4or 5+)		ACCOUN	FANT		COMM	UNICE	4TIONS
	Hygi other	Be C	17. Father's Name (First, Middle, Last)	<u> </u>			18. Mother's Nar		Maiden Sumame	9)	
land	fental rked c	To B	PERCY 1	ERTEE			GE	RTRUDE	- DRA	TON	
Mary	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ms		19a. Informant's Name/Relationship (T)			ng Address (Stree	t and Number or Ru	ıral Route Numbe	er, City or Town, S	State, Zip Co	de)
	1 and 2 Health em 27		JOYCE H. PERI			EKSHUT	Ct.	PHOENIX		211.	31
ore	Pages 1		20a. Method of Disposition 1 Burial 2 Cremation 3 DF	3	20b. Place of Dispo cemetery, crei	matory or other pla	ace)	Date	20c. Location - 0		
Baltimore	Pa men ury		*4 ☐ Donation 5 ☐ Other (Specify)		GREEN MOU	INT CREM	ATORY 6	6.03	DAUTIME	IKE, M	ARYLAND NEKAL Hom.
3al	Departi Departi Importi any Inj		21. Signature of Funeral Service Licens	99	2:	2. Name and Addr	ess of Facility V	AVAHN C	C. GREE	NE FUI	
	40240		23a. Part1. Enter the disease, or comp	ications that caused the	doath Do not on	405 yo	KK NUM		MORE, 1		proximate
	_		shock, or heart failure. List only o	ne cause on each line.	a deathir Do not en		101	or respiratory at	1031,	Int	terval Between nset and Death
	Pnysician /Medical		disease or condition resulting in death)	a_ Pulm	فالمحدد	en	bo Cus				
	Examiner			Due lo (or as a c	onsequence ou:	60			Ē		
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of):						
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
oʻ	execut en and rial-trar	Exa	resulting in death) Last	Due to (or as a c	onsequence of):						
8760,	The law requires that the death certificate be executed the bas been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical	(d							
9	ing ph	Φ	IF FEMALE:								
Box	leath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 [Fetal death 3	∃Ectopic pregnan	су		23d. Date Mon	of delivery th Da	y Year
	the a	Physician/M	1 Yes 2 No	4□Pregnant at tim 9□ Unknown	e of death 5[Other (specify)					,
P.O.	that the de led by the a detached f	H.	Part II. Other significant conditions co	ntributing to death but n	not resulting in the u	inderlying cause g	Iven in Part I.	23e, Did t	obacco use contri	bute to the c	ause of death?
Records,	ires tha signed I d be det	Completed by	Dichetes					10	Yes 2□No	3 Probably	y 4√2 Unknown
Ö	w require been si should I	ete	11	urin				24a. Was	an 24h W	lara autonev	findings available
Reć	sician: The law scertificate has b irector, page 2 s	E D	Lidbra to	u troix				autop	osy po rmed? de	rior to comple eath?	etion of cause of
<u>a</u>	in: Ti		25. Was case referred to medical				26 Plans of Do	1 ☐ Yes ath (Check only o		☐ Yes 2	No
of Vital	Physician: this certifical	To Be	examiner?	lospital:	2 ER/Outpaties	nt 3 DOA	thos		dence 6 Othe	r (Specify)	
10	g Phy er thi		27. Manner ol Death	28a. Date of Injury (Month, Day Y				,	now injury occurre		
0	ath. r: Aft	atlo	1 □Natural 5 ♥ Pending investigation	(World), Bay	out/ Injury		Yes 2 □No				
Division	r Atte er de recto by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, larm, st Specify)	reet, lactory, office	•	281. Location (S City or Tox	Street and Numbe	or or Rural Ro	oute Number,
	ital o irs eft ral Di led in			1							
	Hosp 14 hou Fune Fely file	ical	(Check only 2 Medical Exam	sician: To the best of n iner: On the basis of ex	amination and/or in	th occurred at the evestigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as state nd due to the	d. e cause(s)
	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) 29b. Signature and title of certifier	and manner stated		29c. Licer	nse number		29d. Date signed	(Month, Day	/, Year)
	F 3 F 8	2	STOOL	11/	no	DO	06176	.5	TUAN=	7th.) cont
1	1		30. Name and address of persons of	ompleted caus of deat	h (Item 23a) (Tuno	Print)			0000	1 0	(005
				ZUAINCO	3350 W	JILKEN	SAUE	#307	BALTIK	TOKE	1005 MD 21229
	Sta	ate	31. Date liled (Month, Day, Year)	32. degistrar's	Signature	and a					
	Regist		JUN 1 5 21	105 Elisera	, St fig	A STATE OF THE STA					

Porter, Warren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** aul'ne 16NR 9:45 AM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Ofty, Town, or Location of Death Examiner Quail Run Assisted Living Perry Hall
Under 1 Year | If Under 24 Hrs.
onths | Days | Hours | Min. Baltimore Birthplece (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 M 2 € Months Director 92 12/23/1912 221-28-8639 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itams 23a 21234 3415 Acton Road U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 X No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. À 3X Widowed 4 □ Divorced White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. nt: If item 27 is marked other than " DElaware Home and Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12 Nurses Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Haves Georgia Thiamengos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13804 Manor Glen Road - Baldwin Maryland 21 of Disposition (Name of Date 20c. Location City or Town, State 21013 Christian G. Hayes (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or ` 4 ☐ Donation 5 ☐ Other (Specify) 06/25/2005 Baltimore, Maryland Greek Orthodox Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 asseln 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) Read Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diesaco or ir jun) that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 0 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X bursing Home 5 Residence 6 Other (Specify) P hours after death. Inerat Diractor: After this y filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1-Natural fnjury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a 1/5/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 600 we 13 2005

DHMH 17 Rev 1/2001

State Registrar 30. Name and address

31. Date filed (Month, Day Year)

ORIGINAL

Ec. 6

of person who completed cause of death (Item 23a) (Type, Print)

11

32. Registrar's Signature

			State of Maryland / Dep		-	_	•
				rtificate of Death	Ra	g. No. 200	5 19010
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yea	3. Time of Death (
	/Media		THOMAS JOSEPH PEARSON	1	May	24 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Do	
	Funeral		WCI, 13800 McMullen HWY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Cumberland If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Allegan	y Birthplace (State or Foreign Country)
	Director		212-64-3084 1MM 2□F 51 Yrs. Usual Residence of Decedent	Months Days Hours Min.	April 30,	1954 M	aryland
	yland now		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mar e-fst	ctor	MD Prince George's Upper Mar	lboro			1 ∑Yes 2 □ No
	ith the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What	Country?
	s 23a	ral	4700 Governor Ogle Ct.	20772		U.S.A.	merican Indian,
	ter de	Funeral	1 Never Married 2 Married 1 TYes 2 V No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, W	
99	el', or		3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-1 show ts Modical Examiner is ust be notified at	Completed by	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work	ing 1	6b. Kind of Busine	ss/Industry
121	within ane. then	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	hanic		Merchant	Tiro
	filled v Hygie other i	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name			1116
Jan	ld be ental ked o	To Be	Eugene E. Pearson, Sr.	Garnet (). Knight		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event. It e Mexical Examiner must be notified at Once.	-		ng Address (Street and Number or Run			e, Zip Code)
	and 2 salth a n 27 I			Box 138, Oceanvie		.9970	
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	osition (Name of matory or other place)	Date 2	0c. Location - City	or Town, State
ij	t. Par ntmen rtant:			coln Cemetery 05/2			, Maryland
Bal	permi Depar Impor any ir			2. Name and Address of Facility Gas 739 Baltimore Ave			
K	Physician		23a. Part 1. Enter the disease, or complications that used the death. Do not en shock, or heart failure. List only one cause in each line.		or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or fondition resulting death) a. End/ Stage Liver Due to (or as a consequence of):				10 years
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. He patitis A , B , $\&$ Due to (or as a consequence of):	C +			20 years
	cuted nd ransit	cal Examiner	that initiated events c.				4
0	te be executed ysician and e burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
68760,	physic the b		d.				
Вох 6	death certificate be executed e attending physician and id for use as the burial-transit	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of o	delivery
.O. B	0 0	Physician/Med	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year
s, P.	requires that the leen signed by th hould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	w requires been sign should be				1 🗌 Yes	2 X No 3□	Probably 4 Unknown
Record	aw ls b	Completed			24a. Was an autopsy		autopsy findings available o completion of cause of
	The ate h page	Com			perform		?
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	Othor	n (Check only one		
of	Phys r this ral dir	T.	1 ☐ Yes 2 ☑ No	TIL 3 DOX 4 Norsing No	me 5 Residen 28d. Describe hov	nce 6X Other (S)	pecifyPrison
lon	nding th. :: Afte e fune	atlor	1 X Natural 5 ☐ Pending (Month, Ďaý Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,		Rural Route Number,
_	d hours		29a. Certifier (Check only 29a. Certifyi 3 hydician: To the basis of examination and/or in	th seebined at the time, date and place, overstigation, in my opinion, death occurr	and due to the cat	ase(5) and manner te and place, and d	as statud. ue to the cause(s)
	thin 2 thin 2 the I	Medical	one) and manner stated. 29b. Signature and title of penifier	29c. License number		d. Date signed Mo	
}	¥ ¥ ¥ 8		1 / / / / / / / / /		20	5/2	4/05-
	11/		30. Name and ad less of plan who completed cause of death (Item 23a) (Type	D0055881		1	10-
1	•			Hwy, Cumberland, 1	Maryland	21502	Į.
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	book			

JOSEPH PECORA
WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . Day 2005 JUNE 12; 12:36 **Physician** Joseph Angelo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CO TOWSON ST JOSEPH MEDICAL CENTER | HUnder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | June 20, 2 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 12 M 2 ☐ F Yrs 2002 220-63-7122 2 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State tams 23a or 28a-f show Parkville 1 ☐ Yes 2 XNo Baltimore Director 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number USA 21234 Itams 23a 9207 Satyr Hill Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Itam 27 is marked othar than "natural", or Itams 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ann Latham Geraldine John Pecora ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Itam 27 is any Injury or othar trau once. John Pecora/father 9287 Satyr Hill Road, Parkville, MD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 06/1672005 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
14 Donation 5 XOther (Specify) Entombment

Commetery, crematory or other place)

Dulaney Valley Mem. Gardens Timonium, MD. Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 21. Signatore of Fure 21204 1050 York Road, Towson, MD S. Coster 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Drowning Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9☐ Unknown 9 Unknown á 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed þ рe 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed page 2 should peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? 1X Yes 2 □ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1xxYes 2 □ No 2 this To tha Funaral Diractor: After the completely filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: subject drowned 1 Natural 5 Pending Formed 1 Yes 2 No 6/12/05 investigation 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town. State) 9267 Satyrtill PUKUIII 4, 415 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 207 Satyritill Rd POOL Swimmine a Funaral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

We Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JUNE 13, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21201 NMO 111 Penn Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 5 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			Please Type or Print in Black Indelible ink. Ens		-	_	
			State of Maryland / Department of Health		ental Hyg	iene nos	1001.1.
_			Registrar Certificate of Deat			og. No.	13344
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2	Date of Death Month	Day Year	3. Time of Death
	/Medic		Pauline F. Rohrbaugh		June 10	7	5:30 AM ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locatio			4c. County of Dea	
2			Homewood at Crumland Farms Frederic 5. Social Security Number 6. Sex 7. Age (In vis. last birthday) If Under 1 Year If Under		Date of Dist	Freder	
33	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1	rs Min.	3. Date of Birth Month, Day July 17	Year 1922 M	thplace (State or Foreign ountry) aryland
0	JII COLOI	1	Usual Residence of Decedent		July 1.	,	ar y rana
D.	how		10a State 10b. County 10c. City, Town or Location Frederick Frederick				10d. Inside City Limits
10 m	8 -8	cto	Maryland Frederick Frederick				1 □ Yes 2 XNo
£ £	or 28	Dire	10e. Street and Number 10f. Zip Code		10	og. Citizen of What C	ountry?
55 $70D$; death with the Maryland	236	Funeral Director	5507 Woodlyn Road 21703			U.S.A.	
3	tems ar	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Control of H	: Origin? (Spec ican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whi	
6/10/65 -0036	o di		1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Speci 1 ☐ Yes 2 No Speci 1 ☐ Yes 2 No Speci	cify:		Specify: Wh:	ite
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	o na	piet	(Specify only highest grade completed) (Give kind of work done during m	most of working	3	TOD. KING OF BUSINESS	viridustry
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Value build to	Ments arked atic e	To	Paul F. Fout	Mabel	Mossbu	ırg	
Maryland 2121	h and Mental Hygiene. 7 Is marked other than " Iraumatic event, ILe Me.		19a. Informant's Name/Relationship (Type, Print) Clarence A. Rohrbaugh, Husband 5507 Woodlyn Roa				Zip Code)
and I and	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, Ite Medical Examinations in colling at once.		<u> </u>	Da		20c. Location - City or	Town State
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Baltimore	Depa Impo any ir		MOO255 Keeney and	Basfor	d PA Fu	neral Hor	ne 21 7 01
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Splital	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	caic	29a. Certifier (Check only (Check only (Deck only (Che	and place, an	d due to the ca	use(s) and manner as	s stated.
The H	the Fi	ledicai	one) and manner stated.				
o ^L	con Too	Σ	29b. Signature and title of certifier 29c. License number 29c. License number	er 6/	29	od. Date signed (Mont	n, Day, Year)
100	10		Crow (Court)		4	110/60	000
10			29c. License number 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Pax, Yaar) 5 2005 32. Jegistrar's Signature	17:19	Erlen	de md	21701
	Sta	te	31. Date filed (Month, Day, Yaar) 5 2005 32. Jegistrar's Signature			7 0	- / -
	Registra	ar	JOH T J COOL STEPPEN ST. PORTER				

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 20b perfh G844 6-15-05 tas of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jun 9, 2005 Year **Physician** 10:30 a Izetta L. Rucker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore Catonsville Commons If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Nov 7, 1934 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Md. **Funeral** 1 □ M 2/□ F 70 Yrs. Director 216-30-7934 Usuat Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at Baltimore 1 Yes 2 No Director N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 515 Mt. Holly Street 21229 filed within 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black þ Specify 3 Widowed 4 Divorced 'natural', Completed The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Hygiene. Homemaker 12 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked othing any liquy or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie N.G. Hooks Soloman Hooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Mt. Holly Street Baltimore, Md. 21229 Shelton Rucker Husband 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Garrison Forest
Metro Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/16/05 Catonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sellvice Licent 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician Sno Steel /Medical Due to (or as a consequence of): **Examiner** abely Sequentially list conditions, Be Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 2□ No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Intury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gtoryville . TURAKHIA 1009, Freder 32 Registrar's Signature 31. Date filed (Mo State Registrar

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I			giene Reg. No. 0	05	9946
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	/Medic Examin		4a. Facility Name (If not institution, give		II Kashel	4b. City, Town,	or Location of Deat	<u>June</u>	4c. County		: 50_A
ı	LXaiiiii		4990 Sentir	nel Drive	#403		Bethesda	l.		Montgom	ery
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H	Director		Usual Residence of Decedent	W	86 Yrs.			July 10	, 1918	Ira	n
	land		10a. State 10b. County		10c. City, Town or L	ocation.				10d. In	side City Limits
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	r 28a	Director	10e. Street and Number	Jomes y		10f. Zip Code			10g. Citizen of V	What Country?	
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-f show ts Modes Exariirer must be mailied at	ed b	15. Decedent's Ed	Year or Dates:	16a, Dec	edent's Usual Occu	pation		16b. Kind of B	Wh usiness/Industry	ite
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di.	of Health of Health itam 27 i		Dana A. Rashti/	Son	20b. Place of Disp	Jasons .	Path Walt	Date, Mas		City or Town, S	
Jor	ages or of f		1 ☐ Burial 2 X Cremation 3 ☐		cemetery, cri	ematory`or other pla	ice)				
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		*4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer			mery orium, Ir 22. Name and Addr					
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	To the Hos within 24 h To the Fur completely	Med	29b. Signaty e and title of certifier	and manner si	lateu.	29c. Licen	se number		29d. Date signe	ed (Month, Day,	Year)
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7	177		30. Name and address of person who	completed cause of	death (Item 23a) (Type		2001103/		Jun	e 13, 2	כטט
	(Alan M. Weintraub	M.D. 55	30 Wiscons	in Avenue	#750 Ch	evy Chas	e, Mary	land 208	815
	Sta		31. Date filed (Month, Day, Year)	5 2005 Regis	ar's Signature	Come					
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State of Maryland / Department of Health and Mental Hygiene

1- For Amend Items 4a,b,29d per Dr., C8/4:06/15/95dbb

Reg. No. 2 1 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ROWLAND 2005 10:02 MM WILLIAM MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMER SPRING HOUSE BOTHOSI) A FUNDER 1 YEAR If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or PAgn Spuntry) 6. Sex **Funeral** 5. Social Security Number Days Months 1 M 2□ F Hours Min. -5834 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov must be notified at **¥€**Yes 2. 🛣 No Director MONTGOMER BETHESDA 10e. **49 2.5**Number 10f. Zip Code Citizen of What Country? Do 814 LANC Funeral 12. Was Decedent Ever in 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 1042 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. 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Marital Status other treumetic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 2 No 1950 1□ Yes No Maryland 21215-0036 9 Specify: Be Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nti: if item 27 is marked other then "nry or other treuments. College (1-4or 5+) Elementary/Secondary (0-12) 12 AGENT GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PENN Charence ROWLAND 10ms NAME 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308K 9208 CELAR WAY PATRICIA KIORDAN MB BOTHESDAI Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Montgomery Crem. Inc. 6-11-05 Bethesda, CHR vy `4 □Donation 5 Nother (Specify) FH/Bethesda-Chase, Inc Robert da A. of Paumphrey 21. Si nature - Funeral Servio Rolla 1.4 Wisconsin Aye. 20814 wall Bethesda Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EMPHUSEMA /Medical **Examiner** POLMONARY DISTE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physiclan/Medical Examiner as the burial-transit The law requires that the death certificate be executed OSTEO ARTHRITIS IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RTENSION 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence and Other (Sp. 1) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To LILHM 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 Z No 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funerel [29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06/14/2005 Les 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TULL JUN 1 5 2005 32. Registrar's Signature State Registrar

		1	For State		State of Ma	ryland /	-	tment ificate				~ .	nd had bee	t on our	
			State Registrar I. Decedent's Name (First	est Middle Last)			Cert	ilicate	OIL	- Calli	2. Date of De	Reg. No.	J U 5	3. Time of Death	}
И	Physicia	n	John	Danie	1 Scha	ller					Month 6	Day 14	Year	6:021	М.
	/Medic Examin		a. Fecility Name (If not					4b. City, T	own, or	Location of Death		4c. Co	unty of Death	1	
	LXamin	~ .	Baltimore R.			ded Ca	re	-		imore		1	1/4		
	Funeral	5	. Social Security Number	er 6. Sex		e (In yrs. last b	inthday)_	If Under 1 Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Co	nplace (State or Forei untry)	gn
	Director	-	220-03-0852		M ZUF	83	Yrs.				May 12	, 1922	2 MI)	
	and and	-	Usual Residence of Dec 10a. State 10b	c. County		10c. City, To								10d. Inside City Limi	is
	Mary fied :	ğ	MD. E	Baltimore	9	Dur	ndalk							1 ☐ Yes 2X	lo
	r 28a	Director	10e. Street and Number					10f. Zip (Code			10g. Citizer	of What Co	untry?	
	th with	aiD	6526 Colgat	e Avenu	е			2	1222			USZ	7		
	eep .	Jer	11. Marital Status		2. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decede Yes, speci	ent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Ame Black, White		
36	2 should be filed within 72 hours after deeth with the Maryland and Montal Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumsite ovent, the M. decal Examinal must be notified at aumsite event, the M. decal Examinal must be notified at	by Funerai	1 Never Married 3 Widowed 4		1X Yes 2 ☐ 1 If Yes, Give Year or Dates:	No	1 [☐ Yes 2	X No	Specify:		Sp	ecity: Wh	ite	
Ö	hour tural			Decedent's Edu		16	a. Decede	ent's Usual	1 Occupa	ation		16b. Kind	of Business/	Industry	
5	in 72 n "na	Completed	(Specify of	nly highest grade	College (1-4or 5	i+)	(Give k life. D	rind of worl O NOT use	k done d e retired,	luring most of work)	ing				
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yla	Ment Arkac arkac	၉	John Danie						/2:	and Number or Rui			- State 3	Sin Code)	
Mar	12 sh h and h and 7 is rr traurr		19a. Informant's Name/ Christine S							Avenue,				р Соов)	
e,	1 and Healtl am 2	1	20a. Method of Dispositi		MITE	20b. Place	of Dispos	ition (Nam	ne of		Date		tion - City or	Town, State	
MO	Pages ent of nt: If it ry or c		1 XX Burial 2 □ Cr 4 □ Donation 5 □		emoval from State			atory or ot Taith (ery June	17,2005	Rosed	dale,	MD.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Merial Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show amportant: if item 27 is marked other than "natural; or items 23a or 28a-f show ampiritury or other traumatic event, the Modest Examinar must be notified at once.	Ī	21. Signature of Funera	al Service Licens	780	00 -				s of Facility Uneral H					
	HD = 4 G		23a. Part 1: Enter the di shock, or heart fai	lisease or compl	cations that caused	the death. Do	7 not ente	110 S	olle e of dvin	ers Point	Road,	Dunda arrest,	Lk,MD.	21222 Approximate	
			shock, or heart fai Immediate Cause (Fina						,					Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	-		a consequence								unknow	61
	Examiner														
	B =	ner	Sequentially list condition if any, leading to immediate cause. Enter Underlyin Cause (Disease or injuries)	ions, uiate	Due to (or se	в полведнеги	ө сту								
	ecuter and -trans	Examine	Cause (Disease or injust that initiated events resulting in death) Last		Due to (or as	a consequenc	e of):								
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687	icate phys s the	edical			J					-					
Box (eath certific attending pl for use as I	M/C	IF FEMALE: 23b. Was decedent pre	egnant 2	3c. If yes, outcome		4b 2 🗆	Catagia as				23	d. Date of de		
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P.0	at the de by the	hys	9 🗆 Unknown								an Did	tahaasa usa	oontributa k	the cause of death?	
	es tha igned be del	by	Part II. Other significar	nt conditions co	ntributing to death t	out not resulting	g in the un	ideriying c	ause giv	en in Part I.		Yes 2	,	obably 4 Unkno	
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Vital		o Be	25. Was case referred examiner? 1 Yes 2 No		Hospital: 1 Inpati	ent 2 ER/	Outnation	t 3 D0	Oth				Other (Spe	cifv)	-
of		H	27. Mangrer of Death		28a. Date of Inju	ury 28t	. Time of		28c. Injun		28d. Describe			**	
ion	Attending F r death. actor: After by the funer	atio	1 ▼Natural 5 2 ☐ Accident	5 Pending investigation	(MOTILI, De	ly rear;	Injury	М		Yes 2 □ No					
Division	r Attendi er death. ractor: A by the fu	Certification:	3 ☐ Suicide 6	6 Could not be determined	28e. Place of In	jury - At home tc. (Specify)	, farm, stre	eet, factory	y, office		28f. Location City or To	(Street and i own, State)	Number or R	ural Route Number,	
ā	ital or irs aft ral Di			/	1						1.1				
	To the Hospital or Attent within 24 hours after death To the Funaral Diractor: completely filled in by the	edical			sicien: To the best iner: On the basis of and manners										
	o the	Me	29b. Signature and title	e of certifier	0			290	c. Licens	se number		29d. Date	signed (Mon	th, Day, Year)	
	- 5 - 0		29b. Signature and title 30. Name and address Tohn S. Lah 31. Date filed (Month,	_ 5.	Carl,	mD.			34	359 (0	410)	6 1	4 20	05	
: 7	a		30. Name and address	s of person who o	ompleted cause of	death (Item 23	а) (Туре,	Print)				1		. 04	
11	J		John S. Lah	L, m.D.39	oo Loch 1	EvenB	oule	vard	Be	Itimore	ma-	ylan	d 2/2	-18	
		ate	31. Date filed (Month,	Day, Year)	32 Regist	trar's Signature	Ana	Me)							
	Regist	rar	ปูปเ	IN T 9 YOU	DE TONIE	C 15	1								

		For State Registrar	State of Ma		partment of F e <i>rtificate of</i>	lealth and Me <i>Death</i>		ne No2005	1991.0
		1. Decedent's Name (First, Middle, Last	")				Date of Death		3. Time of Death
Physicia	an	Marie Nancy Snarsk					June	11 2005	1:30 A M
/Medic Examin		a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	1
		Stella Maris Hospi			Timon		- 18:0	Baltimo	
Funeral		5. Social Security Number 6. Se 119-07-2278	ox 7. Ago □M 2 💢 F	e (In yrs. last birthda 83 Yrs.	y) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye ctober 2	9. Birth Cou	iplace (State or Foreigr intry) aryland
Director		Usual Residence of Decedent					CCODCL 2	J, 1 J _ 1 1 1	
how		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 X No
ene. than "naturel", or items 23a or 28a-f show ne Modical Examilitar ust be notified at	cto	Maryland Baltimor		Balti			100	. Citizen of What Cou	
B or 2	급	10e. Street and Number 134 Hopkins Rd.			10f. Zip Code 21212			United Sta	-
ns 23.	erai	11. Marital Status	12. Was Decedent	Ever in U.S. 13		Hispanic Origin? (Speci an, Mexican, Puerto Ric		14. Race - Amer	ican Indian,
or item	by Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XI If Yes, Give	No	If Yes, specify Cub		can, etc.)	Black, White	
	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:						
"natu	etec	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. Dec	cedent's Usual Occupive kind of work done O NOT use retire	pation during most of working d)	16	b. Kind of Business/I	ndustry
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-f show amportant: if Item 27 is marked other than "naturel; or items in the natified at any injury or other treumetic event, the Modical Exa. Illust must be natified at ance.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Homemaker			Own Home	
other ent.	e C	17. Father's Name (First, Middle, Last)				18. Mother's Name (
rked (To Be	Frank D'Anna				Gianett I)'AngeLo		
and is mail		19a. Informant's Name/Relationship (7			-	and Number or Rural I			ip Code)
n 27 i		Stanley J. Snarsk	i, Jr./sor		Sussex	Rd. Towso		21286 c. Location - City or	Fown State
if Iter or oth		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □	Removal from State	cemetery, c	sposition (Name of crematory or other pla	ica)			
rtant: rtant: njury		* 4 □ Donation 5 □ Other (Specify		Dulaney	Valley Mem	Gar June 14	+,2003	TIMONTUM,	raryiand -
any ir		21. Signature of Funeral Service Licen	to Dollar		Mitch 6500	essotFacility eIl-Wiedefo York Rd.	eld Fune Baltimo	eral Home, ore, MD 2	lnc. 1212
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nding pl use as t	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2∏Estania araggan	24		23d. Date of del	•
e attending physicie id for use as the bur	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of del Month	ivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4b. City. Town, or Location of Death street and number) (If not institution, give **Examiner** NOTE 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funera! 83 1**X**M 2□ F -2888 214-18 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28e-f show the Medical Examinat must be notified at 1 □ Xs 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death . Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If itam 27 is markad othar than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify þ 3 Widowed 4 ☐ Divorced IRC Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (0-12) College (1-4or 5+) 7 is markad othar traumetic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Method of Disposition 1 Burial 2 Femation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee HO.MD Approximate Interval Between Onset and Death Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** lung Aucs /Medical Due to (or as a consequence of): Examiner 45CVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician a should be detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has le 2 certificate 1 Yes 2 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2. No 4 Aursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) tha Funaral Director: After that the fulled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral D 29a Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 61000

State Registrar 31. Date filed (Month, Day, Year)
33. Regi

30. Name and address of person who completed cause of death (Mem 23a) (Type, Print)

32 Registrar's Signature

			1 - For Stata Registrar	State of Mary	land / Dep	artment of H	lealth and M	lental Hyg		
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Las Sophie	Stunkle	5	45 Ch. Town		2. Date of Dea Month June	7, 2005	11:50 ä
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give 5709 Tuscarora 5. Social Security Number 6. S 214-36-0449	Road	yrs. last birthday, Yrs.	Tuscar	Ora If Under 24 Hrs. Hours Min.	8. Date of Birth	Freder 9. Bi	
	ס	tor	Usual Residence of Decedent 10a. State 10b. County	erick	c. City, Town or Lo		arora		, 200p	10d. Inside City Limits 1 Nes 2 No
	th with the 23a or 28	ai Direc	10e. Street and Number 5709 Tuscarora Ro	ad		10f. Zip Code	21790	1	0g. Citizen of What C	S.A.
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, the Medical Evanies must be rediffied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	within 72 ho jane. r than "natur the Medical	ompieted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	Lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of worki)	ng	16b. Kind of Business U.S. Posta	
ryland ?	should be filed nd Mental Hyg marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) George Edward Po	age			18. Mother's Name Virginia	(First, Middle, 1 Remmic	Maiden Sumame) .k	
	1 and 2 sh Health and em 27 Is n ther traun		19a. Informant's Name/Relationship (1 Sally Summers/Decay)	aughter	5709 bb. Place of Dispo	Tuscarora	Road, Tu	iscarora	, City or Town, State, , Maryland 20c. Location - City o	1 21790
Baltimore,	permit. Pages Depertment of I Important: If ite any njury or of		1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify 21. Synature of Funeral Service Licen)	Removal from State /)	ount Oli	matory or other place Vet Cemet 2. Name and Addres Cecney and	ery June	20, 20	05 Freder	
	Pnysician /Medical		23a. Part1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that leaused the cone cause on each line. a. Acute My Due to (or as a cor	death. Do not en	ter the reason dying				Interval Between Onset and Death
68760,	ate be executed whysician and hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	•	Vascula sequence of): ty Syndr	r Acciden	t with ne	europath	У	Years
P.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pri 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	quires that in signed b uld be deta	by	Part II. Other significant conditions of Osteoarthritis;	ontributing to death but not Failure to Ti	resulting in the u	nderlying cause give	on in Part I.		oacco use contribute t es 2 12 No 3 □ P	o the cause of death? robably 4 Unknown
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ion of Vita	Attending Physician: The death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	f 28c. Injury Work		ne 5 Aeside	e) once 6 Other (Spectar) ow injury occurred	acify)
Division	or Dir	Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp				City or Town		
	To the Hospital within 24 hours a To the Funeral I Completely filled	Medical	29a. Certifier (Check only one) 2 Madical Examone) 29b. Signature and title of certifier	ysician: To the best of my liner: On the basis of exar and manner stated.	knowledge, death	29c. License	number	ed at the time, da	ause(s) and manner a ate and place, and dur 9d. Date signed (Mon	e to the cause(s)
) []			30. Name and address of person who o	completed cause of death	(Iteg 23a) (Type,	D547		1 .=	June 8, 2	005
	Sta Registr		Allen Reilly, M. 31. Date filed (Month, Day, Year)	D., 801 Tol. 32. Registrar's S	ionaturo		, Frederi	ck, MD	21701	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month HELEN MARY SAWYER 2005 June 10, 9:35 a 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Adelphi Prince George's Hillhaven Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 7, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 🗓 F 88 Washington, DC 577-07-0110 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Riverdale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 6621 61st Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Data Processor Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna Mary Glororis Edwin B. Wallach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6405 60th Avenue, Riverdale, Maryland Jeanne Jacobs, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/16/2005 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Furneral Service Lieensee 4739 Baltimore Ave., Hyattsville, MD 20781 1101373 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Market Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): <u>Demen</u>tia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? Gastroesophageal Reflux Disease 24a. Was an autopsy performed? 1 Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ar title of certifier June 13, 2005 D53337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 Lockwood Drive #205, Silver Spring, Maryland Dorothy Seay, MD

Registrar DHMH 17 Rev 1/2001

Physician

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Examiner

Funeral

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Items 23a

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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32. Registrar's Signature

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			1 - For State of Maryland / Department	artment of Health and M rtificate of Death		iene 19. No. 2005	19953			
	Dhyoisi	010	Decedent's Name (First, Middle, Last)		2. Date of Death Month	n Day Year	3. Time of Death			
	Physici /Media		KURT EDWARD SCHUMACHER		June 12	2, 2005	13:50p ^M			
	Examir	ıer	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
			7010 Allison Street	Landover Hills If Under 1 Year If Under 24 Hrs.		Prince G				
	Funeral Director		5. Social Security Number 6. Sex $1 \boxtimes M$ $2 \square F$ 7. Age (In yrs. last birthday) $1 \boxtimes M$ $2 \square F$ 53 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Aug. 28	9. Bin Co 1951 Was	thplace (State or Foreign buntry) Shington, DC			
			Usual Residence of Decedent		Aug. 28	, 1931 Was	siiring con, DC			
	yland		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits			
	Maria di	ţċ	Maryland Prince George's Hyattsvil	1e			1 X Yes 2 □ No			
	or 28	ire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?			
	23a	Funeral Director	7010 Allison Street	20784		U.S.A.				
	tems	luel	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. V	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
36	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28a-1 show ite Maylical Examinar must be notified at	by Fi	1 Never Married 2 Married 1 X Yes 2 No 19/0−	1 ☐ Yes 2 🕅 No Specify:		0	nite			
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b	othe vant,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	faiden Surname)				
<u>Iar</u>	Aenta Aenta rked tic a	ToE	Edward George Schumacher	Dorothy	Jane Pf	lugshaupt				
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	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic avant, Ite Medical Examinar must be notified at			Mellowdew Court,						
Ore	Pages 1 nent of Hi ant: If itan		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Dispo	natory`or other place)		0c. Location - City or				
Ē.	tmen tant:		4				, Virginia			
Baltimore,	permit. Pages 1 and 2. Department of Health ar Important: If item 27 Is any injury or other trau			Name and Address of Facility Gas 1739 Baltimore Aver			•			
п			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arre	st,	Approximate Interval Between			
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Ö	al or A s after il Direction	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)				
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier (Check only (Ch	occurred at the time, date and place, a	and due to the cau	use(s) and manner as	stated.			
	tha H in 24 the F	ledical	one) and manner stated.							
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,	11	2	Theoden My for med	OCME	J	June 1 3, 20	005			
	7//		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 111 Penn Street	Baltim	ore, Maryl	and 21201			
7	CI	to	THEODONE M. Kangung 31. Date filed (Month, Day, Year) 32. Registrar's Signature			.orce intry	21201			
	Sta Registr		JUN 1 5 2005 France 15- 1	bode						
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			1 - For State Registrar	State of Mary		artment of F rtificate of			R	leg. No.	05	199	154
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Lasi Theodore Holbro Holbro Halbro	ook Siegel		4b. City, Town, o	r Location of		2. Date of Dea Month June 13	3, [□] 2005	Year O	3. Time of 1:04	
	Funeral		205 E. Joppa Rd. 5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	Towsor If Under 1 Year Months Days	Il Under 24	Adio	B. Date of Birth (Month, Day)	9. Birth	place (State o	or Foreign
	Director		218–18–2927		B1 Yrs.	cation			Dec. 28	1, 1923		Hampsh Hampsh 10d. Inside C	
	th the Mary or 28a-f shi	irector	MD Baltin	nore	Towson	10f. Zip Code				10g. Citizen o	I What Cou		2 No
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mirportent: If item 27 le marked other than "naturel" or items 23e or 28e-f show any injury or other traumatic event, If a Medical Examinar must be notified at page.	by Funeral Director	205 E. Joppa Ros 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates:	MM TT	21 286 Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican, Specity:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	USA 14. R B	ace - Ameri ack, White, aify:		
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nd	should be filed and Mental Hygis marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Charles Siegel				Edith	h l	(First, Middle, Holbrod	ık			
e, Mar	1 and 2 sh Health and em 27 le m		19a. Informant's Name/Relationship (T) Patricia Siegel/ 20a. Method of Disposition	/wife	205 E	ng Address (Street . Joppa F sition (Name of	Road #8		Towson	1000	2128	6	
altimore,	nit. Pages artment of ortent: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signatury of Funeral Service Lipens)	Hilltop S	natory or other place OVC. Corp Name and Addre	. 06		2005	Towso	n, Mai	ryland	т
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	rcate be executed XB physician and street transit and street transit and the burial-transit	Examiner	if any, leading to immediate Cause (Disease or injury	b. Due to (or as a cor									
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth			Check only or				
Division of Vital Records,	tending Phys leath. tor: After this the funeral dir	ation: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	1 ∐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Injur Wor	y at k? Yes 2 No	28	e 5 eside 3d. Describe ho			y)	
Divis	irec n by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Sp	pecify)				of. Location (Si City or Town	n, State)			iber,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ledical	29a. Certifying Phy (Check only one)	rsicien: To the best of my iner: On the basis of examenand manner stated.	knowledge, death mination and/or in	n occurred at the tirvestigation, in my o	ne, date and pinion, death	place, an occurred	d due to the cand at the time, d	ause(s) and r late and place	nanner as s , and due to	tated. the cause(s	;)
)	Veith To t	W	29b. Signature and title of certifier	1751C1	AN	29c. Licens	e number	94		9d. Date sign		Day, Year)	-
	ioti		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Print)				= , T	· ~ ·	ion	286
	Sta Registr	7.3	JUN 1 5 200	7. Registrar's S	ignature for	de							

		_	For Stata Registrar		e of Ma	ryland /		artmen <i>rtificat</i>					Rag. No	En C	05	19	955
	Physicia	an	1. Decedent's Name (First, Midd	le, Last)								2. Date of De Month	Da	у	Year	3. Time o	
	/Medic	al	Donald Wilt Sh									June 1		005		8:01	L A.M
Ť	Examin	er	4a. Facility Name (If not institutio	_	d number)					Location of	of Death			. County o			
	un a val		10801 Fox Hunt 5. Social Security Number	6. Sex	7. Age	(In yrs. last	birthday)	Po to		If Under	24 Hrs.	8. Date of Bir		ontgo		,	or Foreign
Di	uneral rector		007-10-3362 Usual Residence of Decedent	1 X M 2□		93	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 21	y, Year)	912		olace (State ntry) 1sylva	
72 hours after death with the Maryland	how		10a. State 10b. County			10c. City, To	own or Lo	ocation							1	10d. Inside C	·
е Ма	8e-f.s	Director		gomery		Potor	nac										2X No
vith th	De no	Dire	10e. Street and Number					10f. Zip						izen of W			
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ter d	The I	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Arme	ed Forces?					n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)			, White,		
urs a	el', or	þ	3 X Widowed 4 □ Divorced	If Yes	s, Give or Dates:	° 1937- 1965	-	1 ☐ Yes	2 No	Specify:				Specify:	Whi	ite	
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within ene.	than the Mac	nple	Elementary/Secondary (0-12)		ge (1-4or 5	+)	`life.	DO NOT us	e retired)		9	Uni	ted S	Stat	es	
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should be find Mental F	mark	٦ ا	Harry Shive 19a. Informant's Name/Relation:	hin /Tyne Print)	1	Oh Maili	na Address	(Street		ia Wi	Lt al Route Numbe	ar City o	v Town 9	State Zir	Code)	
d 2	7 is trau		Donald W. Shiv			1		-				Ralei					2761
1 ar	item 2 other		20a. Method of Disposition	C, JI./	2011	20b. Place	of Dispo	sition (Nan	ne of			Date				own, State	2/01
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nit. P	# in		21. Signature of Funeral Service			1	Ce	meter 2. Name an	y d Addres	s of Facilit	200 y Rob	ert A.	Pum	phrey	on 7 Fui	Virgin neral	iia Home
Dep	any ir		MA Ch	h.		M013	53 B	ethes	da-C	hevy Maryl	Chas	ert A. e, Inc. 20814-	75: 350	57 Wi	Lsco	nsin A	venu
Phys	sician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause	on each lin	the death. D	o not en	ter the mod	e of dyin							Approxima Interval Be Onset and Years	ite Itween Death
/Me	edical		resulting in death)			consequen		c rar.	LUIC							iears	
⊏xa	miner	_	Sequentially list conditions, if any, leading to immediate			ensio										Years	
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ficate	phys s the	edic		0													
The law requires that the death certificate be executed	attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant			of pregnancy	a [75-4						23d. Date	of delive	эгу	
death	e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ F	regnant at	2 🗌 Fetal dea time of death		⊒Ectopic pr ⊒ Other <i>(sp</i>						Mon	th	Day	Year
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	cate ha	Con											rmed? 2 X No		eath?	2□ No	
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Attending r death.	the	Certification:	3 ☐ Suicide 6 ☐ Could	not be	Place of Inju	ry - At home,	farm, st					28f. Location (Street an	d Numbe	r or Rura	l Route Nun	nber.
offe	Direct d in by	erti	4 Homicide determ	t t	ouilding, etc	. (Specify)		,	,			City or To	vn, State)			
e Hospital	To the Funeral Direc completely filled in by	edical C	29a. Certifier 1X Certifyi (Check only one) 2 Medical	ng Physician: T Examiner: On t and	o the best of the basis of manner sta	examination	dge, deat and/or in	h occurred vestigation,	at the tim in my or	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and man d place, ar	ner as s	tated. the cause(s)
To the within 2	To the complet	Me	29b. Signature and title of certific	or /	. 0	/		290	. License	number			29d. Da	te signed	(Month,	Day, Year)	
			Harres	16 6	11	7		VA	01	0109	500	97	Jun	e 1	3 3	2005)
A		2	30. Name and address of person	who completed	cause of de	eath (Item 23	а) (Туре,	Print)		<u> </u>	~			•	9		
J.	N		Kenneth G. Pu	gh, M.D.	NNN	IC, 890	01_W:	iscons	sin	Avenu	e, B	ethesda	, Ma	ryla	nd	20889	
	Sta		31. Date filed (Month, Day, Year	IN 1 5 2	32 Registra	Signature	Bs.	iscons	The same	,							
	Registr	ar	J	MISTOR	A	Sague	1	20									

		State of Maryland / Department of Health and M. State Unpend Item 23a&27 per me G844 6-23-05 tas Registrar Certificate of Death	ental Hyg	giene Reg. No. 2005	1995
Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last) Paul Michael Sauerwald 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Dea Month June	4c. County of Death	
Funeral Director		3127 Wallford Drive, Apartment A 5. Social Security Number 1213-64-7840 Usual Residence of Decedent	8. Date of Birtl (Month, Day 03/12/1	Baltimore (A Year) (1952 MC	place (State or Foreigntry)
d within 72 hours after death with the Maryland piene. rr then "neturel", or Itams 23a or 28a-f show Ite Medical Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 3127 Wallford Drive, Apartment A 21222		10g. Citizen of What Cou USA	
'2 hours after de tatural', or Itams	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Force) 15. Decedent's Education 16a. Decedent's Usual Occupation	Rican, etc.)	14. Race - Amen Black, White, Specify: Whi	etc. te
be filed within tal Hygiene. d other than "	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Service Technician 18. Mother's Name		Fiber Opti Maiden Sumame)	С
12 s h ar 7 ls trau	우	Edward L. Sauerwald 19a. Informant's Name/Relationship (Type, Print) Tina Sauerwald-McClain (daughter 129 Research Large. 2011)	Route Numbe		o Code)
Pages 1 nent of He ant: If itar ury or oth		20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of commetery, crematory or other place) Hilltop Service Corp. 06/13	3/2005	20c. Location - City or Towson MD	
permit. Departr Imports any inji	_	21. So, ture of Funeral Service Licensee 22. Name and Address of Facility Dud & 7922 Wise Ave. Dund & 7922 Wi	alk,MD.	21222	Approximate Interval Between
/Medical Examiner prize	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Dise Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate autos. Exit of Johnship Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ase		Onset and Death
the death certific y the attending p iched for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)		23d. Date of delive	ery Day Year
equires the	leted by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to the	4
G CT	е Сотр	25. Was case referred to medical 26. Place of Death		ned? prior to condeath? Description of the condeath? Description of the condeath? Description of the condeath?	psy findings availat mpletion of cause of 2 No
anding Physath.	Certification; To B	examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom 27. Manner of Death 1 Anatural 5 Pending (Month, Day Year) Injury 28a. Date of Injury 28b. Time of Injury Work? 1 Yes 2 No	e 5 Reside	ence 6 Other (Specify ow injury occurred	
Hospita 4 hours Funaral (ely fillec	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the ca	ause(s) and manner as st ate and place, and due to	tated. the cause(s)
To tha within 2 To tha Complet	Me	29b. Signature and title of certifier 29c. License number OCME		9d. Date signed (Month, June 10, 200	
)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Baltime	ore, Marylar	nd 21201
Sta Registr		31. Date filed (Month, Day, Year) JUN 1 5 2005 Registrar Signature			

			1 - For State Registrar	tate of Mar	yland / Depa		of H	ealth a	and N	,		005	19957
	Dhi.		Decedent's Name (First, Middle, Last)	0: 1						2. Date of De	ath	Van	3. Time of Death
	Physici /Medi		Fredericka A.	Stroh						June	13	2005	7:04 A ^M
	Examir	ner	4a. Facility Name (If not institution, give stre			4b. City, T			of Death		4c. 0	County of De	ath
			North Arundel Hospi 5. Social Security Number 6. Sex		In yrs. last birthday)	Gler If Under		rnie H Under	24 Hrs.	8 Date of Bir	_ A	nne Ar	
	Funeral Director			2⊠ F	98 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Aug. 0	iÿ, _{Year)} 5 190	6	irthplace (State or Foreign Country) MD
	pu ,		Usual Residence of Decedent							77.03.			
	show	2	10a. State 10b. County		0c. City, Town or Lo	cation	Dac	adena	3				10d. Inside City Limits 1 Tyes 2X No
	the M	ect	Maryland Anne Art	inde		10f. Zip (auenc			10a Citiz	en of What (
	3a or	10	200 Southwood Road			101. Zip 1	Code	2112	22		log. Citiz	US	
	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or itams 23a or 28a-1 show int, the Medical Examinar must be notified at	Funeral Director		Was Decedent Eve	er in U.S. 13.	Was Decede	ent of His	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))- 1·	4. Race - An	nerican Indian,
92	after or its	/Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 Yes, speci 1 ☐ Yes 2		Specify:		Hican, etc.)		Black, Wh Specify:	white
21215-0036	hours tural',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:									
5	in 72 n "nai	Completed	15. Decedent's Educati (Specify only highest grade co	mpleted)	(Give	lent's Usual kind of work DO NOT use	l Occupa k done d e retired)	tion uring mos	t of work	ring	16b. Kin	d of Busines	s/Industry
212	d with giene.	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)		Sales	s C16	erk				Retai	1
	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic evant, the M	Be C	17. Father's Name (First, Middle, Last)							e (First, Middle		Sumame)	
yla	should be ind Mental I	ပ	Herman Rossman					Ida		Schramr			
Maryland	d2sh thanc 17Isn traum		19a. Informant's Name/Relationship (<i>Type</i> , William H. Stroh	(son)	19b. Mailir 200	g Address Sout	<i>(Street a</i> hwoc	nd Numbe Id Ro	ad.	al Route Number Pasaden	er, City or a, MD	Town, State,	Zip Code) 2
	tam 27 tam 27 othar tr		20a. Method of Disposition	•	20b. Place of Dispo	sition (Nam	e of			Date	20c. Loc	ation - City o	or Town, State
E O	Pages lent of nt: If it ry or c		1 XBurial 2 ☐ Cremation 3 ☐ Rem 14 ☐ Donation 5 ☐ Other_(Specify)		Cedar Hil				June 20		Balti	more.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atler death with the Marylar Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Marical Examinar must be notified at once.		21. Signatur of Funera S vic Ucensee	/		. Name and	Addres	s of Facilit	ty		ngs F	unera	1 Home, P.A.
			23a. Parti. Enter the disease, or co-plicati shock, or heart failure. List only one of	ons that caused the	e death. Do not ent							ב טויוט	Approximate
	Pnysician		Immediate Cause (Final disease or condition	Acy 7	C M	4.2	Cai	rde	5/	Int	205	7	Interval Between Onset and Death I'm in edicaTe
	/Medical Examiner		resulting in death)	Due to (or as a c		(maracaje
	LXammer	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	2222242222 of								
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Ć,	cate be executed obysician and the burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a c	onsequence of):								
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89	ntifica ng ph s as th	Med	IF FEMALE:										
Вох	ath ce ttendi or use	ian/	23b. Was decedent pregnant 23c.	If yes, outcome of p 1☐Live birth 2 [Fetal death 3	Ectopic pre					23	Bd. Date of de Month	elivery Dav Year
0	v requires that the death certific been signed by the attending F should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□ Pregnant at tim 9□ Unknown	e of death 5	Other (spe	cify)					WOTE	Day Toal
P.0	that the	y Ph	Part II. Other significant conditions contrib	uting to death but n	ot resulting in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	e contribute	to the cause of death?
Records,	quires n sign ald be	d by	Congestiv	e U.	POUT	F	411	u- 8	2_	10	Yes 2	No 3□F	Probably 4 Unknown
000	aw requir s been si 2 should	plete	J							24a. Was		24b. Were a	autopsy findings available
Ä	The lav ate has page 2:	Completed								autor perfo	ormed?	prior to death? 1 \(\sum \) Ye	
Vital	cian: artifica ictor,	Be (25. Was case referred to medical examiner?					26. Place	of Death	h (Check only o	(
of \	physic this call dire	은	1 ☐ Yes 2 No	1 L Inpatient	2 ER/Outpatien		-	4 17 140		me 5 Resid			ecify)
on (ding Physician: The h. h. After this certificate ha funeral director, page	lon		8a. Date of Injury (Month, Day Yo	ear) 28b. Time of Injury	28 M	Work			28d. Describe	now injury	occurred	
Division	er death ractor: by the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	8e. Place of Injury	- At home, farm, stre		-	es 2 □ i	-	28f. Location /5	Street and	Number or F	Rural Route Number,
Θ	al or /	Certification:	4 Homicide determined	building, etc. (Specify)	,				City or Tov	vn, State)		,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deliached for use as the burial-transit	Medical (29a. Certifier (Check only one) Certifying Physicial Call Examiner:	n: To the best of n On the basis of ex and manner stated	amination and/or inv	occurred a restigation, i	t the time	e, date and inion, deat	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner a place, and du	as stated. te to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	1			License		_				nth, Day, Year)
			Mayer So	tales "	40	0	2	193	8		Jun	ec.	3 2005
	V		30. Name and address of person who comp		h (Item 23a) (Type, I	Print)	/	-	-0				D 21061
W.			31. Date filed (Month, Day, Year)	22 Pagintene's	Cianatura			001	150	5/Ph	DUr	ace of	2 2/00/
	Sta Registr		11111 4 F 0	05	Signature A.	South.	و						
DHI	MH 17 Rev 1/2	001	JUN 1 5 21	The party	w di	STATE OF THE PARTY							

ORIGINAL

			1 - For Stete Registrer	State of M	aryland /		artment rtificate			nd Me		giene Reg. No.	2005	1005
ı	Physici /Medi		1. Decedent's Name (First, Middle, La Hildegard				Stro	nst	4	-	Date of Dea Month	Day /C/	Yeer	3. Time of Death
ı	Examir Funeral	er	4a. Facility Name (Enot institution, gines of the School Security Number 6.3	oplains to	Hospitaliani	aL birthday)	Bal- If Under	Year	Location of If Under 2	e C	Date of Birth		ounty of Death N/A 9. Birth	
	Director		324-50-0212 Usual Residence of Decedent 10a. State 10b. County	1□M 2ÅF	51	Yrs.		Days	Hours	Min.	Date of Birtl (Morith, Day 1/14/5	3		place (State or Foreig ntry) inois 100. Inside City Limits
	th the Mary or 28a-f sh	Director	NJ Glouces	ter	W.	Dep	tford 10f. Zip (•			10g. Citize	n of What Cou	1 X Yes 2 □ N
036	e filed within 72 hours after death with the Maryland il Hygiene. other then "neturel", or liems 23a or 28a-f show vent, i'ra Medical Examirac must be molified at	by Funeral	7 Cortland Wa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	?	- 1	Was Decede f Yes, speci 1 Yes 2		0805' spanic Origi n, Mexican, Specify:		fy Yes or No- can, etc.)		Hace - Ameri Black, White, pecify: White	can Indian, etc.
9500-612121	led within 72 ho lygiene. her then "netur nt, in wedical in	Completed	15. Decedent's E (Specify only highest gr	College (1-4or		Sa. Deced (Give life.		epti	ionist			Acc	of Business/In	·
≧	2 should be fi and Mental H is marked otl aumatic ever	To Be	17. Father's Name (First, Middle, Last Peter 19a. Informant's Name/Relationship	G	ammel	9b. Mailir	ng Address (Hi	1dea		Ka	umame) S†1 own, State, Zip	o Code)
e, E	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trai once.		Roy Stro	fy)	20b. Place	7 Co of Dispo tery, cren 21 L c	ortlan sition (Name natory or off IWN Cr ! Name and	d Wa e of ner place emat Address	ory cory	ntua Dat 6/15, Stall	N.J. 05 lings	0805 20c. Loca Brid uner		own, State
	Physician /Medical Examiner	l Examiner	23a. Par 1. Enter the disease, or conshock, or hearthilure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as c. Respi	d the death. Done. n Met. a consequence brace a consequence a consequence a consequence	o not ent								Approximate Interval Between Onset and Death Day Day Day
<u> </u>	death certificate e attending phy: od for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 ☐ Fetal dea t time of death	5 🗆	Ectopic pre	cify)			One Diday		d. Date of delive	Day Year
cords,	law requires that the as been signed by th 2 should be detache	ompleted by	Part II. Other significant conditions	contributing to death b	ut not resulting	ji⊓ the ur	nderlying car		n in Part I.			es 2 🗆 i	No 3∏Prob	he cause of death? pably 4 Munknown psy findings available
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5	ding Phys h. After this funeral di	ertification; To E	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ry 28b	Outpatien Time of Injury		c. Injury Work	4 14015	280	5 Reside		Other (Specificcurred	y)
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			State of Maryland / Department of Health and 1- State of Maryland / Department of Health and Certificate of Death		ene g. No.2005	19950
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	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea BALTIMORE	ith	4c. County of Death	
	Funeral Director	2	5. Social Security Number 1 6. Sex 1 59 Yrs. The security Number 219-40-3554 6. Sex 1		Year) 9. Birthp Court May	lace (State or Foreign try) Yland
	the Maryland 28a-f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	ith the	Funeral Director	10e. Street and Number 10f. Zip Code 21214	10	g. Citizen of What Cour	try?
	ter death w Itams 23a	uneral	11. Marital Status 12. Was Decedent Ever in U.S. Amad Forces? 13. Was Decedent of Hispanic Origin? (1) If Yes specify Cuban Maxican Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
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21	within 72 h ene. than "nati	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) Machinist Machinist	orking	6b. Kind of Business/Ind	dustry
nd 21	be filed w tal Hygie d othar ti evant, th	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (California Name)	ame (First, Middle, M	Iaiden Surname) V	13/600
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	of Health itam 27 i	3	Bernice T. lemple (Wyle) 3008 Echodole 20a. Method of Disposition 20b. Place of Disposition (Name of cempter), crematory or other place)	$A_{\text{Date}}, B_{\text{Date}}$	16. MD 1 Oc. Location - City or To	JJJ Ψ wn, State
altimore	t. Pa		1 Seurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	114/05	Balto. 1	121(04)
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3	Priysician		23a. Part 1. Shier the disease, or complications that caused the death. Do not enter the mode of dying such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ic or respiratory arre-	st,	Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions b.			
	ecuted and I-transit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of):			
8760,	be eo ician buria	dical Ex	resulting in death) Last Due to (or as a consequence of): d.		1 100	
Вох 68	death certificate e attending phys d for use as the	0	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	ry
P.O. B	that the death ed by the atter detached for	Physician/M	in the past 12 months? 1		Month	Day Year
	Se un ec	by	A sale from the significant continuous continuous to death but not resulting in the underlying cause given in Part I.		acco use contribute to the	e cause of death?
ecor	S D Z	Completed		24a. Was an autopsy perform	24b. Were auto	osy findings available npletion of cause of
Vital Records,	ysician: The lav is certificate has director, page 2	Be Col	25. Was case referred to medical arguments 26. Place of De	1 Yes 2 eath (Check only one	□ No 125\Yes	2∐ No
n of \	Phys	on: To		Home 5 Resider 28d. Describe how	nce 6 Other (Specify w injury occurred)
Division of		Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rura State)	Route Number,
Ö	To tha Hospital or Attand within 24 hours after deatl To tha Funeral Director: completely filled in by the	al Ceri	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place	e, and due to the car	use(s) and manner as st	ated.
	To tha Ho within 24 I To tha Fu completel	Medical	(Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occard manner stated. 29b. Signature and title of certifier 29c. License number		te and place, and due to d. Date signed (Month,	
			• Quell OCME	J	NE 9,2005	
Y -	1	1111	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBLO, MO 1111 Penn Street	Baltimore	e, Maryland	21201
	Sta Registi		31. Date filed (Month, Day, Year) 32 Alegistrar's Signature			

Theresa Lynn Triplett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04050 State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a,pt.II,27 per me G846.8-16-05,tas
Registrar Registrar Registrar NJM 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Triplett Theresa Lynn 1615 2005 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Baltimore Good Samaritan Hospital | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Jan. 1 1968 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F Maryland 37 215-84-4570 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County or 28a-f show ns 23a or 28a-f shor 1 ☐XYes 2 ☐ No Baltimore Maryland NA 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21214 6040 Harford Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) iral', or flems ? 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ∐Yes 2 No filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced "natural" or than "natura Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Home Maker NA 7 la marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental C. Bavis Marv R. Triplett Milton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21224 f Health (326 South Lehigh Mary C. Witomski (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State June 16,2005 East Point, Maryland * 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 oncer 1 ann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebral Hemorrhage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 3 Hepatitis C and Human Immunodeficiency Virus Infections 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 2 □ No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 反 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 0 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined 4 Homicide filled in within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME June, 14, 2005 1 runca TOU r ilo

State Registrar

DHMH 17 Rev 1/2001

Name and address of person

31. Date filed (Month, Day, Year)

PATRICIA

111 Penn Street Baltimore, Maryland 21201

who completed cause of death (Item 23a) (Type, Print)

32. Refistrar's Signature

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JUN 1 5 2005

	1 - For State Registrar	State of Maryla	nd / Department of h Certificate of	lealth and Menta		5 19961
Physician /Medical Examiner Funeral Director	1. Decedent's Name (First, Middle, L. 4a. Facility Name (If not institution, g. 5 - 1 - 1 - 2 - 1 + 5 5. Social Security Number 220-14-4544 Usual Residence of Decedent	Ethel	4b. City, Town, c	or Location of Death A + 1 m 0 r-L If Under 24 Hrs. B. Da Hours Min. (M.	te of Death porth Day Yea 1 1 1 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 2:13 PM
death with the Maryland ms 23a or 28a-f show triust be neithed at an erail Director	10a. State 10b. County	timore 10c. C	ity, Town or Location Ba	altimore	10g. Citizen of What	10d. Inside City Limits 1 ★ Yes 2 No Country?
5-0036 Thours after death with the Manatural; or Items 23a or 28a-f silles! Examinat must be notified.	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of H If Yes, specify Cubin 1 Yes 2 X No	21207 dispanic Origin? (Specify Yean, Mexican, Puerto Rican, Specify:		S.A. nerican Indian, nite, etc. Black
2121 ad within rgiene. er than ". t. tre Me.	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las	rade completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire: Hom	during most of working d) nemaker	16b. Kind of Busines Own Middle, Maiden Sumame)	ss/industry Home
Maryland nd 2 should be file tith and Mental Hy 27 Is marked oth r traumatic event	Joseph 19a. Informant's Name/Relationship Zollie D. Bagby son-in-la			and Number or Rural Route	Katie Austin Number, City or Town, State d. 21207	, Zip Code)
Baltimore, M. permit. Pages 1 and 2 Deperment of Heath is Important: If item 27 is any njury or other tra	20a. Method of Disposition 1 XI Burial 2 Cremation 3 4 Donation 5 Other (Spec	□Removal from State ify)	Place of Disposition (Name of cometery, crematory or other place Arbutus Memorial F 22. Name and Addre	Park 06/13	20c. Location - City of Baltimo	or Town, State ore, Md.
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rds, P.O. Box 68 quires that the death certifica n signed by the attending phuld be detached for use as the day Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	1	al death 3 □Ectopic pregnancy death 5 □ Other (specify)		23d. Date of d Month e. Did tobacco use contribute 1 □ Yes 2 □ No 3 □ F	Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification; To Be Completed by Physician/Medical Examir	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatic investigatic	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Work	26. Place of Death (Checker) ar: 4 Nursing Home 5[4 at 28d. De	autopsy prior to death? Yes 2 No 1 Yes	s 2 No
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral Medical Certification;	3 Suicide 6 Could not determined	building, etc. (Specif	ome, farm, street, factory, office	28f. Loc City	ation (Street and Number or F r or Town, State)	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	29b. Signature and title of certifier	and manner stated.	owledge, death occurred at the time time the time that the	pinion, death occurred at the	to the cause(s) and manner a time, date and place, and du 29d. Date signed (Mon	e to the cause(s)
State Registrar	30. Name and address of person who Opr. Ming Yi 3320 Bensor 31. Date filed (Month, Day, Year) JUN 1 5 2	n Avenue Baltimore, N	Maryland 21227 13	altimore	Marylan	d 21227

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 9: 16PM June Willis Ouinn 12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritum Hospital Baltmore Baltimore art Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ★M 2 ☐ F Date of Birth (Month, Day, Ye 12–4–21 Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs. Director 83 254-30-7312 Usual Residence of Decedent Ga. the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avant, the Madical Examinal must be notified at 1**X** Yes 2 □ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 N. Caroline Street 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 X No Specify: Black Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Salesman Clothier permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 ia marked other any injury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willis Lillie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 906 N. Caroline St., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Mem. Park 6-17-05 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Due to (or s a consequence of): Ashvation Due to (or at a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Artery Dixarc 1 Yes 2 No 3 Probably 4 Unknown Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hyperlension 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Hospital or Attanding Physician: 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification; 28d. Describe how injury occurred Injury death. 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours atter of Punaral Dirac 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) To tha within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 12,200S RES 000 SEOI, LOUR RAVEN BUD 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21239 Good Saman'tan Hospital Gaurav Khanna 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 5 2005 Registrar Elsew & Sports

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Division of Vital Records, P.O. Box 68760,

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		For State	State of Ma	arylan			Health and M	lental Hy	/giene	2005		1070
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/Medio Examin		4a. Facility Name (If not institution, give	street and number)	/	111		or Location of Death	June		County of Deat	h	P
		Maryland Gre	neral,	NOSI	ital.	Paltim	we Cry	ly		i	1A	
Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In y/s.	ast birthday) Yrs.	If Under 1 Year Months Days		.(Month. Da	rth ay, Year	9. Birt	hplace (State	or Foreign
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with the	Dire	10e. Street and Number	H 01	1		10f. Zip Code	212	7	10g. Ci	tizen of What Co	untry?	
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2 sho		19a. Informant's Name/Relationship (T	· ·				and Number or Rura	1 manual		or Town, State, Z	(ip Code)	
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Physician		Immediate Cause (Final disease or condition	a. Mul:	tiple	e H	emor	Rhagic	- ()+	OK	e	Onset and	Death
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of	100,0	DERRA	0				
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as	CONSEQU	rence of the	ring	DISTAR	<u></u>	-			_
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	End St	age	L'e	nac.	Disla	50		İ		
be executed cian and burial-transit	Exa	resulting in death) Last	Due to (or as	a wisequ	ence of):							
cate be	dical	•	d		-				W653			
The law requires that the death certificate b tite has been signed by the attending physic bage 2 should be detached for use as the b	by Physician/Medica	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv							
atten for u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3□E	Ectopic pregnanc Other (specify)	у		1	23d. Date of deli Month	,	Year
that the de ed by the detached	hys	9 Unknown	9□ Unknown									
signed I	by P	Part II. Other significant conditions co	ntributing to death be	ut not resu	lting in the und	derlying cause giv	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of	death?
w require been signature	ted							10	Yes 2	□No 3□Pro	bably 4 🖺	Unknown
na taw has b ge 2 st	Completed							24a. Was autop	osy	24b. Were aut	opsy findings ompletion of	available cause of
ician: Tha t certificate ha rector, page		05.18						1 ☐ Yes	2 No	death? 1 ☐ Yes	2□ No	
Physician: r this certifica ral director. p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 🗆	ER/Outpatient	3 DOA Oth	26. Place of Death			- Flori 10		
g Phy er this ieral d		27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time of	28c. Injur	y at 2	8d. Describe f			ify)	
andin sath. or: Aft	atlo	1 Natural 5 Pending 2 Accident investigation	(Mortal, Da)	i Gai)	Injury	M 1	Yes 2 □No					
or Att. fter de piracto n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubul	ry - At hor . (Specify)	me, farm, stree	et, factory, office	2	8f. Location (5 City or Tov	Street an	d Number or Rui	al Route Num	n <i>ber</i> ,
pital ours a garal Dilled i		29a. Certifier 15 Certifying Phy	nining T. the best									
To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certifica completely filled in by the funeral director.	edical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examinati	ion and/or inve	stigation, in my c	me, date and place, a pinion, death occurre	nd due to the and at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(:	s)
To th within To th comp	Me	29b. Signature and title of certifier	. 01'	mire	bah im	29c. Licens	e number		29d. Dat	e signed (Month	Day, Year)	
2		shoul ?	01 1011	MIVE	MD	8	4548		6	e/8/0-	5	
5		30. Name and address of person who co	ompleted cause of de	eath (Item	23a) (Type, Pi	rint)	& Grener	~1	ilno	140)	
Sta		31. Date filed (Month, Day, Year) [N]	/// // // // // // // // // // // // //	1/0	1/10	MIGH	o OTTIKA	al 1	103	NI KK		
Sta Registra		JUN .	T 2 2003934			-/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09^{Day} 2005 **Physician** 11:40p Wagner Jüne Ronald Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Village Montgomery Village Health Care Ctr Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 22,1962 6. Sex Birthplace (State or Foreign
Country) **Funeral** Days Hours 1**X** M 2□ F 376-76-7737 Director 43 California Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event. It a Madical Exertinar must be notified at Maryland Frederick Ijamsville 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4739 Mussetter Road 21754 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√DYes 2 □ No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 😿 No Specity: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Arlo Wagner ၉ Janet Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an tant: If item 27 ts r jury or other traur Sandra L. Wagner/Wife 4739 Mussetter Road, Ijamsville, Maryland 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Jun 12, 2005 Smithsburg, Maryland 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
M00706 106 East Church St, Frederick, Maryland 21701 21. Sign turn of Funeral Service Licent 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Neoplasm of Bone disease or condition resulting in death) 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit be executed attending physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2XNo Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4v Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.Funeral Director: After ti Certification: Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Thomicide To the Hospital within 24 hours a To the Funeral C 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

State

Baltimore, Maryland 21215-0036

Box 68760

P.O. P

Division of Vital Records,

31. Date filed (Month, Day, Year) JUN 1 5 2005

120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Vinu Ganti, M.D.,

19529 Doctor's Drive, Germantown, Maryland 20874

DHMH 17 Rev 1/2001

Registrar

29c. License number D41162

29d. Date signed (Month, Day, Year)

June 10, 2005

			State of Maryland / Department of He Amend Item 4a per phy G844 6-15-05 tas Certificate of D	ealth and N eath	Mental Hyg	iene eg. No. 2 (05	· ·	996!
			1. Decedent's Name (First, Middle, Last)		2. Dete of Deet Monter	h	Vane	3. Time o	of Death
a.	Physicia /Medic		ANNA MARIE WINKLEMAN		6	7 20	year 05	8	pop
	Examin		Ta I comy from (in that motivation, give of our cira frames)		ocation of Deeth	4c. County o			
			Mariner Health 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year	Baltimo If Under 24 Hrs.		Balti			
П	Funeral Director			Hours Min.	8. Date of Birth (Month, Day, Feb. 18	Year) 1915	Country Mary	l and	or Foreign
	D		Usuel Residence of Decedent						
	show	٦	10a. Stete 10b. County 10c. City, Town or Location				100		City Limits s 2XXNo
	28a-f	ecto	Maryland Baltimore Baltimore Coul	nty	1	0g. Citizen of Wh	net Countr		
	3a or	Funeral Director	The state of the s	1237		USA	,	,	
	death	nera	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp.	pecify Yes or No-	14. Race			
2	within 72 hours after death with the Meryland ene. than "ratural", or terns 23a or 28e-f show he Medical Examiner must be motified at		1 □ Never Married 2 □ Married 1 □ Yes XXX No	Specify:	rican, etc.)		, White, et White		
21215-0020	hours tural',	Completed by	XXX Widowed 4 ☐ Divorced Year or Detes: 15. Decedent's Education 16e. Decedent's Usuel Occupation	ion		16b. Kind of Bus			
2	in 72	plete	(Specify only highest grede completed) (Give kind of work done du	ring most of work	king	TOD. KING OF BUS	111055/11100	Stry	
	d with	E	Tth grade College (1-4or 5+) N/A Housewife			Houseke	eping	g-Owr	1 Home
Maryland	be filed tral Hygie of other event,	Be			e (First, Middle, I)		
$\frac{8}{2}$	should ind Men imarke umartic	၉	Charles Fred Hess		Marie Roy		Mada 7:- (To dol	
Z Z	ith end Tian	i	19a. Informant's Name/Reletionship (Type, Print) William Winkelman (Son) 19b. Meiling Address (Street and 4425 Glenmore)						
ā,	s 1 end f Heelth ftem 27 other tu	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of			20c. Location - C			
altimore,	Peges nert of int: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith (6~10~05 E	Baltimor	e, Mo	d.	
a	permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylar Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Licensee 22. Name and Address		ssahn Fu				
œ	89 = 8 9		E. J. Lassahr 7401 Belain	r Rd. Ba	altimore,	Md. 21	236		
	يتخليو		23a. Pert1. Enter the disease, of complications thet caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such es cardiac	or respiratory arre	est,	1 1	Approxima nterval Be Onset and	etween
	Physician Medical		immediate Cause (Final	00	1		1		-05
	Examiner		disease or condition resulting in death)	ciae	WI		-	0 /	
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	cete be executed physicien end s the buriel-transit	dical Examiner	Sequentially list conditions, if eny, leading to immediate						
8760,	be ex icien buriel		Cause (Disease or injury						
687	The law requires that the death certificete be executed its has been signed by the ettending physicien end page 2 should be deteched for use as the bunel-transit) 항	that initieted events Due to (or as a consequence of): resulting in death) Last						
Box	uires that the death certific signed by the ettending p Id be deteched for use es	by Physician/Me	d						
	deati	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23b. Did to	bacco use cont	ribute to t	he cause	of death?
о. О	d by the	Ph			1 □ Y	es 25 No	3 🗆 Probe	bly 4□	Unknown
ds,	signe d be c	ρ			24a. Was a	n autonsv	24b. Wer	e autopsv	findings
Records,	v require been si should	ete			perform		avail	able prior pletion of eath?	to
Ä	he lav e hes ege 2	Completed			1 T Y	n 24 X No		Yes 2	∃ No
ā	an: T	Be C	25. Was case referred to medical	26. Place of Deat	th (Check only on				
<u>></u>	nysici nis ce Il direc	္	examiner? 1 Yes 2 No	ursing Ho	ome 5 Reside	nce 6 □Other	(Specify)		
ב	Ing PI	<u>ë</u>	27. Menner of Death 1	at es 2 □ No	28d. Describe ho	w injury occurre	d		
Division of Vital	Attending Physician: or death. ector: After this certific by the funeral director.	lcat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office	15 2 140	28f. Location (St	reet and Number	r or Rural	Route Nu	mber,
<u>S</u>	or A effer Direction	Ę	4 ☐ Homicide determined building, etc. (Specify)		City or Town				
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification:	29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opin	, date end place,	and due to the ca	tuse(s) and man	ner as sta	ted.	(e)
	the H hin 24 the F	= 1	one) and manner stated.			Od Data diamed	// / / D	au Vaarl	
	5 × 5 00		29b. Signature and title of certifier 29c. License n	2539)	9d. Date signed $6-9$	- 2	000	
	610	1	30. Name and address of person who completed cause of deeth (Item 22c) (Type Print)	1 1	1.	20.00	100	2 -	
	2		30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 31. Date filed (Month, Day, Yeer) JUN 1 5 2005 32. Rejistrer's Signature	1Sal7	smore	11100	42	39	
	Stat	е	31. Date filed (Month, Day, Yeer) 32. Positrer's Signature						
	Registra	ir	JUN I 5 ZUUS MISSELVE ST PARTIES						

			For State - State Registrar	of Maryland	•	artment <i>tificate</i>			nd Me	, ,	iene	005	19966
	Physicia /Medic Examina Funeral Director	an	Month Day Year							3. Time of Death			
		al	A. F. W. N. W. M. A. S. M. M. M. M. M. M. M. M. M. M. M. M. M.	James A.	Warre		our or	Location of	Dooth	Ju	in 11,		1:00 pm M
		er	4a. Facility Name (If not institution, give street and	tico Avenue		40. Oily, 1	OWII, OI		Baltim	more N/A 8. Date of Birth 9. Birthplace (State or Fore			
			5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1	Year Days	If Under 24					place (State or Foreign
			219-38-7700	F 61	Yrs.	MORUIS	Days	Houis	MIII.	Jun 18,			
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits
	the Marylan 28a-f show notified et	tor	Md N/A				Ва	ltimore					1 X Yes 2 □ No
	h the	irec	10e. Street and Number			10f. Zip (Code	.,		10	0g. Citize	en of What Cou	intry?
	23a c	aiD	2533 Quantico Avenue					2121	5			U.S.	A .
	72 hours after death with the Maryland natural, or Itams 23a or 28a-f show Ital Examiner must be notified at	Funeral Director	Ame	Decedent Ever in U.S. d Forces?	. 13. \	Vas Decede f Yes, specif	nt of His fy Cubar	spanic Origi n, Mexican,	n? (Spec Puerto R	cify Yes or No- lican, etc.)	14	 Race - Amer Black, White 	
36	irs aft	by F	If Yès	es 2 □ No , Give or Dates:		I ☐ Yes 2	□ X No	Specify:			٤	Specify:	Black
215-0036	2 hou	ted	15. Decedent's Education (Specify only highest grade comple	(ad)	16a. Deced	tent's Usual kind of work	Occupa	tion	of workin		16b. Kind	d of Business/I	ndustry
21	within 7 ene. than "r	Completed	11. / 1	ge (1-4or 5+)	life. L	DO NOT use	retired)		or working	g		Constr	uction
121	Hygier Hygier Ithar th		12 17. Father's Name (First, Middle, Last)					borer	s Name	(First, Middle, N	Aaiden S	(umame)	
and	d be f ental } ked of	To Be	Douglass Warr	en				TO. WICHTON	3 1 12 11 3		ie Wi	,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic event. If the Maryla Examiner is until to Intiffed at any injury or other traumatic event. If the Maryla Examiner is until to Intiffed at angles.	F	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number	or Rural	Route Number,	City or	Town, State, Z	ip Code)
	and 2 saith a n 27 is		Joyce Warren Wife					Avenue		ore, Md 21			
Baltimore,	Pages 1 nent of He int: If itar iry or oth	1	20a. Method of Disposition 1 1	cor	ce of Dispo netery, cren	sition (Name natory or oth	e of ner place)			20c. Loca	ation - City or 1	
Ē.	it. Par rtmen rtant: njury		' 4 □ Donation 5 □ Other (Specify)	Gar		rest Vete			ry 0	6/20/05		Owings N	fills, Md
Bal	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217										
	1000		23a. Part1. Enter the disease, or complications that caused the dear Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition A UNC (AV UK) The results of the condition of the cause									Onset and Death	
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в	Examiner	_	Sequentially list conditions, if any, leading to immediate	to (or as a conseque	ance off:								
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3760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burlah-transit	icai	d										
9	he death certifical the attending phy ched for use as th	Med	IF FEMALE:										
Box	ath ce attend for us	Physician/M	in the past 12 months?	, outcome of pregnand ive birth 2 ☐ Fetal d regnant at time of dea	téath 3 □	Ectopic pre					23	d. Date of deli- Month	ery Day Year
P.O.	res that the de signed by the a l be detached f	ysic		nknown	ıın b	Other (spe	CIIY)						
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Records,	w require: been sig should b	ed b											
ဝ၁	taw re as bee 2 sho	plet								24a. Was ar autops	n V	24b. Were aut	opsy findings available ompletion of cause of
Ä	ding Physician: The taw n. After this certificate has b funeral director, page 2 s	Certification: To Be Completed								perform	19d?	death? 1 ☐ Yes	2□ No
Vital	Physician: this certificant		25. Was case referred to medical examiner?		<u>-</u>		Othe	~		ath (Check only one)			
of	Phy this ald		1 Tes 2 9 NO		R/Outpatien 28b. Time of	t 3 DOA	1	4 🗆 Nuis		e 5 Aeside 8d. Describe ho		Other (Specoccurred	fy)
Division	Attending For death. actor: After by the funera		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Injury M 1 Injury M 1 Injury						0				
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Ö	ital or A												
	To the Hospital or Attenowithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: T (Check only one) 1 Medical Examiner: On t and										
	o tha o the omple	Med	29b. Signature and title of certifier	nariner stated.				number				signed (Month	
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	di		30. Name and address of person who completed	cause of death (Item 2	23а) (Туре,	Print)	. 44	4 (~	4 4		4 5	40 21804
	1,		GARY COVIEN BY	6569	1 1	CH	ALL	61 1	/ -	MA	ארצי	roke,	40 USY
	sta Registr	- 1	31. Date filed (Month, Day, Year) JUN 1 5 2005	2. Registrar's Signatu	A.	65							
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DHMH 17 Rev 1/2001

			1- State of Maryland / Dep. State of Maryland / Ce	artment of Health and M rtificate of Death	• •	giene	19967				
	Physici	200	1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath Day Yea	3. Time of Death				
	Physici /Medic		Pette M. Webb			L1, 2005	8:37 P M				
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De					
			Gilchrist 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson If Under 1 Year If Under 24 Hrs.	9 Date of Riel		imore				
	Funeral Director		213-62-5418 1- M 2 XF 53 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day May 30	1952 M	Birthplace (State or Foreign Country) aryland				
	ס		Usual Residence of Decedent	<u> </u>	riay 50	,1332 11	ar y rana				
	irylan ihow		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits				
	Ba-f s	Directo	Maryland Baltimore Phoe				1 ☐ Yes 2 No				
	Mith th	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of What					
	eath v	erai	4 Country Club Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21131	eifu Van as Na	U.S.	A. nerican Indian.				
	fter d	Funerai	1 Never Married 2 Married 1 Yes 2 M No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, Wi					
8	al', o	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	White				
20	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show he Wedical Exam her miss be recitied at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	20	16b. Kind of Busines					
2	nen "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	'g						
2	filed w Hygier Sther tl		12 Admi	inistrator	(Final Middle	State of	Maryland				
anc	otal Fed of	Be		18. Mother's Name							
Maryland 21215-0036	should be tand Mental I	2	Rex Wire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailit	I da ng Address (Street and Number or Rura	Comp		Zin Code)				
<u>8</u>						Maryland	21131				
altimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 i any injury or other tra		20a. Method of Disposition 20b. Place of Dispo		ate	20c. Location - City					
Ē	Pages nent of I int: If its iry or o		1 X Burial 2 □ Cremation 3 □ Removal from State Uponation 5 □ Other (Specify) Woodlawn		-2005	Woodlawn	Maryland				
a	permit. Pag Department Important: any injury c once.			2. Name and Address of Facility Ruc			Home, Inc.				
m	\$ Q E # 8		tank tagan	1050 York Road		Maryland					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
	Pirysician	2.1	Immediate Cause (Final disease or condition	olon Cancer			Onset and Death				
	/Medical Examiner		resulting in death) Due to (or as a consequence of):								
		<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):								
16	nsit	nin	Cause (Disease or injury								
4	execu in and ial-tra	Examiner	that initiated events c								
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dicai	d								
9	ng ph	Med	IF FEMALE:								
ROX	eath certific attending p	Physician/Me	23h Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of d Month	,				
	at the dea by the at stached fo	/sici	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)		Month	Day Year				
2	law requires that the as been signed by th 2 should be detache	Ph	Part II. Other significant conditions contributing to death but not resulting in the u	23e. Did tobacco use contribute to the cause of death?							
ds,	uires that signed b	d by	,	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown							
Hecord	w requ	Completed			24a. Was a	n 24h Were	autopsy findings available				
	9 4 9	дшс			autops	sy prior to med? death?	completion of cause of				
_ '	itcian: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death			es 2 No				
	d is	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Othon			ecity) Working				
	ding Ph		27. Manner of Death 1 SNatural 5 Pending 28a. Date of Injury (Month, Day Year) Injury			ow injury occurred					
DIVISION	ttendii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No							
Ž	o d c	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	8f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,				
	To the Hospital of within 24 hours at To the Funeral D completely filled in		29a. Certifier Certifying Physician: To the best of my knowledge death	n accounted at the first date of the	nd du- *- **						
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	d at the time, d	ause(s) and manner a ate and place, and du	ue to the cause(s)				
	To the within Yomph	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mor					
			Mullian	D58303	-	June 12	2005				
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,		500	Δ 2					
			AARON Charles my 6601 N-1	warres of 100.	-0~ M	7 420	†				
	Sta Registra	15	31. Date filed (Month, Day, Year) JUN 1 5 2005 32 Registrar's Signature	and a							

ILUNE 11,2005

			State of Maryland / Department of Health and N Certificate of Death	-							
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	ng. No 2 0 0 5	3 Time of Death					
	Physic		Emilie Cornelia Watson	June	12, 2005	4:00 am					
400	/Medi Examir		4b. City, Town, or L		4c. County of Death	4.00 aiii					
	Funeral Director	ier	Peartree Assisted Living 5. Social Security Number 215-05-0330 Pasade 7. Age (In yrs. last birthday) Amonths Days Hours Min.	ena	Anne 9. Birthpl Coun	Arunde l ace (State or Foreign y l and					
	r 28a-f ehow		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location								
		-	10a. State 10b. County 10c. City, Town or Location		10	Od. Inside City Limits					
	he M	Director	Maryland Anne Arundel Pasadena			1 ☐ Yes 2 ☐ No					
	Might de Might	ä	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coun	try?					
	s 23a	ra	339 N. Ferry Point Road 21122		USA						
020	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow he Mcdical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Wh						
21215-0020		Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	sing	6b. Kind of Business/Ind						
	iled v Hygie ther t	ပိ	+ Homemaker	e (First, Middle, M.		ehold					
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, I'm Monee.	Be	H. Melvin Bull, Sr. Emili	•	effenberg						
<u></u>		ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			Code					
Ma	d2s than 7is trau		M. Latimer Banner III- nephew 339 N. Ferry Point		asadena, MD						
ē,	es 1 and 2 of Health item 27 is r other tra		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or Tov						
no n	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)								
Baltimore	pemit. P Departme Importan any injur.		The croot emacory, The.		Baltimore,						
B	permi Depar Impor any ir		Mush Malexal 3111 Mountain Dd Basadona MD 31133								
			23a. Parl 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	st, 110 21 (2)	Approximate Interval Between Onset and Death					
Egy (Physician /Medical Examiner		Immediate Cause (Final disease or condition and table of the condition and the condi								
		<u>_</u>	resulting in death) a. Due to (or as a consequence of):			- i					
		Aedical Examiner		5 days							
60,	cate be executed physician and s the burial-transit	al Ex	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):	7 10 12	8	tweek					
κ 68760,	ntificate ng phys s es the	Medic	resulting in death) Last	remal	Failure	2 words					
Вох	ath ce ttendi for use	Physiclan/	a Acute me chimic			- 5					
	the ai	ysic	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	acco use contribute to	the cause of death?					
s, P.O	es that the death cer igned by the attendir be detached for use	by Ph	endstype conjective heart fails.	1 ☐ Yes	2 12 No 3 □ Prob	ably 4 ☐ Unknown					
Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and retail director, page 2 should be detached for use es the burial-transit	Completed b		24a. Was an performe	ed? avai	e autopsy findings lable prior to pletion of cause eath?					
<u>~</u>				1 ☐ Yes	2 1 □ 1 □	Yes 2□ No					
/ita	clan: ertific ector,	Be	examiner/	h (Check only one)	/ A:	cs. (de)					
of Vital	hyslo this c	၉			ce 6 (Specify)	Living					
Ē	ing P	ö	1 ☑Natural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	0					
Sic	tend death tor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be	200 1 (201							
Division	or All after of Direction by	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	et and Number or Rural State)	Houte Number,					
_	spital lours seral filled	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the caus	se(s) and manner as sta	bed					
	To the Hospital or Attending Phywithin 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	ed at the time, date	and place, and due to t	he cause(s)					
	vithii To th	W	29b. Signature and title of certifier 29c. License number	29d	I. Date signed (Month, D	ay, Year)					
	<u> </u>		In Marbely in 129767	,	June 12	,2005					
,	-		30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)	0 1							
	V		3-11-61 0 12 0 110	· Pasac	vena, m,	121122					
	Sta Registr		31. Date filed (Month, Day, Year) UN 1 5 32. Registrar's Monature								

Percell Young Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

unpend item/23a,27,28-f, penie, (345),// (5) II

State of Maryland / Department of Health and Mental Hygiene 05-04041 crn 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, 3. Time of Death) Month Year **Physician** OUNG June 13. 2005 12:49 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 9. Bigthplace (State or Foreign **Funeral** 10 M 2□ F Months Days Hours 217.66.6054 Director Usual Residence of Decedent Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Mucical Examiner must be notified at MD ATIMORE 1 Tres 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21202 Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced "naturai" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LABOREX 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be is marked of 1 and 2 should be 10 19b. Mailing Address (Street and Number or Rural Route Number, City SomeRSE t of Health MOTHER MAE 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 ö Department of important: If any injury or once. EMETER) 18.05 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Narcotic Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy Vital 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 🂢 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1X Yes 2□ No of 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury Unk 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 6/13/2005 2 Accident unk Could not be determined 24 hours after deat Funeral Director: 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rura) Route Num City or Town, State) HU Bayview 333 filled in by 4 - Homicide found at hospital Cassell Dr., Baltimore, MD 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) JUN 1 5

ABILLAH

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

OCME

June 14, 2005

Baltimore, Maryland 21201

	•	State Registrar		(Cert	ificate of	Death		Reg. No.		
Physicia	n	1. Decedent's Name (First, Middle, La						2. Date of D		UUZ	3. Time of Death
/Medica			Zander					June	13		9:00 P M
Examine	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o		ath		County of Death	
Funeval		Stella Maris 5. Social Security Number 6.5	ex 7. Age	(In yrs. last birth	hdav)	Timoniu If Under 1 Year		s. 8. Date of B		Baltimor	
Funeral Director			□M 2√F			Months Days	Hours Mi	July 1	Day, Year)	923 Mary	place (State or Foreig ntry) 'land
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or tiems 23a or 28a-f show ont, the Modical Examinar must be notified at		10a. State 10b. County		10c. City, Town		ation				1	10d. Inside City Limits
Ba-f s	cto	Md. Baltimo	re	Phoeni	LX						1 ☐ Yes 2 💢 No
if Health and Mental Hygiere. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Exerciter must be notified at	al Director	10e. Street and Number 2906 Paper Mil	1 Rd.			10f. Zip Code 21131			10g. Citi	zen of What Cour	ntry?
tems er 🗇	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	10-	14. Race - Americ Black, White,	
ural', or I	Completed by Funeral	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:			∵Yes 2√√ No	Specify:			Specify Whit	
nation	ete	15. Decedent's E (Specify only highest gr			(Give ki	nt's Usual Occup ind of work done O NOT use retired	during most of w	orking	16b. Kir	nd of Business/In	dustry
Is marked other than raumatic event, It's M	Comp	Elementary/Secondary (0-12)	College (1-4or 5-	+1	cret		<i></i>			Legal	
d oth even	Be	17. Father's Name (First, Middle, Last						ame (First, Middi		Sumame)	
natic natic	၉	Henry J. Zander						C. Wink			
tem 27 is most		19a. Informant's Name/Relationship (Alvina M. Hamme)				Address (Street				r Town, State, Zip 21131	Code)
Important: If item 27 any injury or other tra		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State		, crema	itory or other plac	·	Date		cation - City or To	
rtant: njury		`4 □Donation 5 □Other (Special	_			Redeeme		7-05		timore,	Md.
any ir		21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or comshock, or heart failure. List only	See /		22. F	Name and Addre Ruck Tows	ss of Facility Son Fune	ral Home	e. Ind		
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		shock, or heart failure. List only	one cause on each line	θ.	or or real	W S	ig, such as cardi	Despiratory	arrest,		Approximate Interval Between Onset and Death
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attending physician and for use as the burial-transit	Medical		d		_						
nding use a:	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						2	3d. Date of delive	an/
ned by the attendi	Physiclan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death		ctopic pregnancy Other (specify)	·		2	Month Month	Day Year
ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
igned to	by Pi	Part II. Other significant conditions		t not resulting in	the und	larlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to th	he cause of death?
been sig should b	edt	1/3 man for						1 🗆	Yes 2	No 3□ Prob	pably 4 Striknown
2 should	Completed							24a. Wa		24b. Were auto	psy findings available
ate ha	E								opsy formed? 2 No	death?	ppsy findings available mpletion of cause of
# 5	Be	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			
0 D	0	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Out	patient	3□ DOA Oth	er: Nursing	Home 5 Res	idence 6	i □Other (Specify	y)
After thi funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of jury	28c. Injur Wor		28d. Describe	how injury	occurred	
or: A	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No				
To the Funeral Director: After th completely filled in by the funeral	Certification;	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, fan . <i>(Specify)</i>	m, stree	et, factory, office		28f. Location City or To	(Street and own, State)	d Number or Rura	I Route Number,
To the Funeral	Medical	29a. Certifier 1 Certifying Pl (Check only one) 1 Medicel Exer	nysicien: To the best of miner: On the basis of and manner state	examination and	death o	occurred at the tin stigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as st place, and due to	ated. the cause(s)
To the Funeral Direct completely filled in by	Me	29b. Signature and title Certifier	2045	12-3	7	29c. License	e number	2		signed (Month,	
/									0	~ "	
5		30. Name and address of person who EDDIE NAKHUDA,				rint) LLEY ROA	ר תדיית מו	NIUM, MI	2100	9.3	
Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signature			2 11110	violi, IIL	. 2.103		
Registra		JUN 1 5 20	05	H A	bas	the same					
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DHMH 17 Rev 1/2001

9:00 P.M.

13,

JUNE

ZANDER

				partment of Health and Men	tal Hygien	2005 19971
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
, dates	/Medic	al	RONALD RICHARD ANDREWS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		005 4:14 PM
	Examir	er	Southern Maryland Hospital Center	Clinton		c. County of Death Tince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. /	Date of Birth Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		216-64-2990	Ju	ly 19 19	955 Washington, DC
	ryland how		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	he Ma 8a-f s	ecto		Marlboro		1 ☐ Yes 2 XNo
	3a or 3	by Funeral Director	10e. Street and Number 11012 Croom Road	10f. Zip Code 20772	10g. C	Citizen of What Country? USA
	death	nera		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian,
36	s after	y Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:	11, 6(0.)	Black, White, etc. Specify: White
5-0036	ilied within 72 hours after death with the Maryland Hygiene. Uther than "natural", or Items 23a or 28a-f show ont, the Medical Exament must be trofitted at	ted b	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	Kind of Business/Industry
21215	ithin 7. ne. nen "n	Completed		Be kind of work done during most of working DO NOT use retired)		Construction
27	filed with Hygiene other tha	Cor	11 FIOU 17. Father's Name (First, Middle, Last)	ase Painter 18. Mother's Name (Fir.	st Middle Maide	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examinar must be indiffied at	To Be	Alexander Andrews	Lydia Payn		
lary	2 should and his mail			ing Address (Street and Number or Rural Ro	_	
	1 and 1 Health em 27 other tr		20a Method of Disposition 20b. Place of Disp	2 Croom Road Upper M		, MD 20772 Location - City or Town, State
altimore,	Pages nent of I ant: If its ury or o		TR Buriet 2 Cremetion 2 Pamount from State cemetery, cre	s Church Cem. 6-1-05		oom, MD
Balti	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signatury of Furieral Service Licensee	2. Name and Address of Facility Eberw 1433 White Pls. La. W	ein Fune	eral Services
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en mock, or heart failure. List only one cause a each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Preumonia			Onset and Death
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	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c.	Y		
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9	tificate ng physi as the I	ledical	u de la companya de l			
Вох	leath certific: attending pl	Physician/Med		⊒Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 (9 ☐ Unknown 9 ☐ Unknown	Other (specify)		World Day Toal
a,	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	undertying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	w require been sig should b			·	1 Yes 2	2 No 3 Probably 4 Unknown
Records,	has b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
_		O	25. Was case referred to medical	26. Place of Death (Ch.	I□ Yes 2 N	
	hysician: this certifica al director, i	To B	examiner? 1 Yes 2 No	Othor		6 ☐Other (Specify)
ouc	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury	of 28c, Injury at 28d, I Work? M 1 ☐ Yes 2 ☐ No	Describe how inju	ury occurred
Division of	ten deatl tor: the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	reet, factory, office 28f. L		and Number or Rural Route Number,
	P H P I	Cert	4 Homicide building, etc. (Specity)		City or Town, Stai	
	To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal physician: To the bes	th occurred at the time, date and place, and d nvestigation, in my opinion, death occurred at	lue to the cause(s the time, date an	s) and manner as stated. nd place, and due to the cause(s)
	To the total	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
,			30 Name and address of person who completed across of death (flow CC). The	10053219	17	24/2005
1	B		30. Name and address of person who completed cause of death (Item 23a) (Type ZAFAR ANSARI, MI) 7 F	IST Office Road in	LALDOR	FMD 20602
	Sta		31. Date filed (Month, Day, Year) JUN 0 1 2005 32. Restrar's Signature	29c. License number DOOS 3219 Print) OST Office Road, N		
	Registr	ar	OUT OIL LOUS POLICE			

			1 - State Registrar	tate of M	aryland / Dep <i>Ce</i>	artment <i>rtificate</i>					Reg. No.	0000	10070
	Physici /Medic		Decedent's Name (First, Middle, Last) GLADYS ALETA BRI	NKER						2. Date of Dea Month MAY 26		005 Year	3. Time of Déath 4. 12:09PMM
	Examir		4a. Facility Name (If not institution, give stre CARROLL HOSPITAL CE	NTER		4b. City, To WES	STMI	Location o				County of Death	
ľ	Funeral Director		5. Social Security Number 485–70–4516 6. Sex Usual Residence of Decedent	XX F	ge (In yrs. last birthday, 95 Yrs.		Days	Hours	Min.	8. Date of Birt Month, Da APRIL	9 (Year)	1910 IC	nplace (State or Foreign Intry) WA
	Maryland B-f show	tor	10a. State 10b. County MARYLAND BALTIMORE	3	10c. City, Town or Le REISTER								10d. Inside City Limits 1 ☐ Yes 2\(\infty\)No
	th with the 23e or 28 Ist be not	al Director	10e. Street and Number 14127 OLD HANOVER RO)AD		10f. Zip 0	^{Code} 136					izen of What Cou IED STAT	•
920	72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show calcal Examitter must be notified at	by Funeral	11. Marital Status 12. 1 Never Married 2 Married X Widowed 4 Divorced	Was Decedent Armed Forces? 1 ☐ Yes 250 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decede If Yes, specif 1 ☐ Yes 🔀		spanic Orig n, Mexican Specify:	gin? (Spec Puerto P	cify Yes or No- Rican, etc.)	-	14. Race - Amer Black, White Specify: WH	
Maryland 21215-0036	C 2	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Secondary (0-12) 12		(Give 5+)	dent's Usual kind of work DO NOT use EMAKER	done di retired)	urina most	of workin	g		ond of Business/li	ndustry
/land	should be filed withir and Mental Hygiene. marked other then metic event, ITB M	To Be C	17. Father's Name (First, Middle, Last) ARTHUR MARK HOEL						's Name CE K	(First, Middle, ING	Maiden	Sumame)	
	s 1 and 2 should f Health and Men item 27 is marke other treumetic		19a. Informant's Name/Relationship (Type, JUDITH B. DAVIS/DAUG	•	1412	7 OLD	HAN			Route Number		r Town, State, Zi VN , MD	ip Code) 21136
Baltimore,			20a. Method of Disposition XX Burial 2 □ Cremation 3XX Rem 4 □ Donation 5 □ Other (Specify)	oval from State	20b. Place of Disponent Place of	matory or oth	ner place	0		/2005		DAR FALL	
Ball	permit. Page Department of Importent: If any injury or		21. Signature of Fyneral Service Licensee	Subo		2. Name and ERS-DU 1 WILL	RBO	s of Facility RAW F STREE	UNER/	AL HOME VESTMIN	P. STEF	A. MD 2	1157
	Physician /Medical Examiner		23a. Part J Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ause on each li	ine.	OCA26			0	respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):								
.O. Box 68	death certific e attending p id for use as	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pred □ Other (spec					2	23d. Date of deliv	rery Day Year
rds, P	as the	ру Р	Part II. Other significant conditions contrib	outing to death b	out not resulting in the u		_	n in Part I.		23e. Did to		ise contribute to	the cause of death?
of Vital Record	The law ate has b page 2 sl	Completed	Right pheumo	HIGIC	î.X					24a. Was autop		prior to co death?	opsy findings available ompletion of cause ol
	Attending Physicien: Th r death. ector: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosi 27. Manner of Death Natural 5 Pending Accident Investigation	oital: 1 Inpatie 28a. Date of Inju (Month, Da			C. Injury Work	r: 4□ Nur at	sing Hom	(Check only only only only only only only only	lence 6	5 □Other (Speci y occurred	(fy)
Division	el or Attendi s after death, il Director: A id in by the fu	Certification:	a Could not be	28e. Place of Inj building, et	jury - At home, farm, st tc. (Specify)	reet, lactory,	office		28	8f. Location (S City or Tow	îtreet and m, State)	d Number or Run)	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical (29a. Certifier (Check only one) 1/1 Certifying Physici 2 Medicel Examiner	an: To the best On the basis o and manner st	of examination and/or in	h occurred at vestigation, in	t the time	e, date and inion, deatl	place, ar	nd due to the o	ause(s)	and manner as s place, and due t	stated. to the cause(s)
)	M With 3	M	29b. Signature and title of certifier	K. G	دادر س		05	number	60		05	e signed (Month,	2005
	WZ		30. Name and address of person who comp	leted cause of c	death (Item 23a) (Type,	Print)	200	22 A	اومد	يو س	esn	MIN STE	21157 i MARULAND
:-	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2	32. Regis	Par's Signature	food	()						

To the		. 10	1		D-319		05/26/	
00	Aed -	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Month,	
To the Funeral D		(Check only 2 Medical Exami	ner: On the basis of exam	knowledge, death ination and/or inve	occurred at the time, date an stigation, in my opinion, dea	nd place, and due to the c	ause(s) and manner as s late and place, and due t	stated. o the cause(s)
el Director: Afterned in by the funera	eruncanon	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe) Injury t home, farm, stree	28c. Injury at Work? M 1 Yes 2 at, factory, office	No	itreet and Number or Run	al Route Number,
this it di		1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	☐ ER/Outpatient 28b. Time of		ursing Home 5 Resid	ence 6 Other (Speci	fy)
ector	o c	25. Was case referred to medical examiner?	Hospital:		Out.	e of Death Check onl or	ne	
page 2	Completed					autop. perfor	sy prior to co	ompletion of cause
s been	ereic					24a. Was a	an 24b. Were aut	opsy findings avail
igne be c	2	Part II. Other significant conditions con	ntributing to death but not	resulting in the und	terlying cause given in Part I	I. 23e. Did to	obacco use contribute to res 2 No 3 Pro	the cause of death bably 4 Unkr
ached for use as	Pnysician/me	in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1	Ectopic pregnancy Other (specify)	222 524	23d. Date of delive Month	Day Year
physicia the bur	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons					
/sician ledical aminer		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a cons					104 64
		23a. Parti Enter the disease, or compleshock, or heart failure. List only of	ne cause on each line.	eath. Do not ente	the mode of dying, such as			Approximate Interval Between Onset and Deat
Importent: fl eny injury o once.		21. Fignature of F. neral Service Licens	88	22.	Name and Address of Facil 4 E. MAIN	iv FLETCHER	FUNERAL F	IOME
tent: ff ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	EVE	ERGREEN	MEM.GARDEN	s 5/29/05	FINKSBURG	G, MD.
item 27 other t		ROBERT K. BOWER 20a. Method of Disposition	201	 Place of Dispos 	DENNINGS R ition (Name of atory or other place)	Date	20c Location City of T	our State
is mar reumati		19a. Informant's Name/Relationship (T)	•		Address (Street and Numb	per or Rural Route Numbe	er, City or Town, State, Z.	
ked oth	lo Be (17. Father's Name (First, Middle, Last) PIERSC	N BOW	/ERS		er's Name <i>(First, Middl</i> e, JOUISE	Maiden Sumame) POULSON	
gene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		MECHANIC		CONSTRUCT	rion
n "natu ladical	Sietec	15. Decedent's Edu (Specify only highest grad	le completed)	(Give k	ent's Usual Occupation ind of work done during mo. O NOT use retired)	st of working	16b. Kind of Business/f	ndustry
in or nearly and wentar rygiene. If item 27 is marked other than "naturel", or items 23e or 28e-f show or other treumetic event, the Modical Examinar must be redified at	a by F	1 ☐ Never Married 2 🔏 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ሺ No If Yes, Give Year or Dates:		☐ Yes 2X No Specify		Specify: WH	
er mu	by Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13, W	/as Decedent of Hispanic Or Yes, specify Cuban, Mexica	rigin? (Specify Yes or No in, Puerto Rican, etc.)		
3a or 2	Dir	10e. Street and Number 1365 OLD WESTM	INSTER RD		10f. Zip Code 21157		10g. Citizen of What Co	untry?
Se-fs	ector	MD. CARR	OLL	WESTM	INSTER			1 □ Yes 25
WOL THE	}	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation			10d. Inside City L
uneral irector		220-16-0166	ÀM 2□F	90 Yrs.	Months Days Hours	Min. (Month, Da	y, Year) Co.	nplace (State or Fl untry) YLAND
		Lorien Nursing 5. Social Security Number 6. Se		rs. last birthday)	Mount Air	y r 24 Hrs. 8. Date of Bir	Carrol	
Examine		4a. Facility Name (If not institution, give		ERS, SR	4b. City, Town, or Location	of Death	26, 2005 4c. County of Deat	
			L. BOW	EDC CD		Month	Day Year	6:40
Physicia /Medica	n	Decedent's Name (First, Middle, Lasi WELDON	")			2. Date of De		3. Time of Dea

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2005 ear **Physician** MAY 27, MAXRAYMOND BROWN 12:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY Rockville Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 75 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1⊠M 2□F Maryland Yrs. 30 Director 213-86-0763 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County outent. It tem 27 is marked other then "neturel", or Items 23e or 28e-f show injury or other traumatic event, the Medical Examiner must be notified at 8. 10a State 10d. Inside City Limits MD Germantown 1 No 2 No Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 20874 19015 Perrone Drive U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Item any injury or other traumatic event, Ite Medical Evantinat once. ☐Yes M☐No Yes. Give Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction llth Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William L. Budd Peggy Sue Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Ellison (Sister) 19015 Perrone Dr., Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, derivatory or other place)

Gate of H eaven Cem 6/1/05 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Pneumocystis Carinii Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Advanced Acquired Immo-defiency Syndrome Dequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Progressive Multifocal Leucoencephalopathy 1 ☐ Yes > SNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificate has autopsy performed? 1 ☐ Yes 3 ₹☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Hospice Hospital: 1 🗌 Yes 2 **X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 🔀 latural 1 ☐ Yes 2 ☐ No 2 🗍 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title ١ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Charles Harrison, M.D. 6001 Muncaster Mill Rd., Rockville, MD 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 1 2005 Registrar

			1 - For State Registrar	State of Ma	aryland		artmen tificate			and M	•	Reg	ene . No. Z	005	The state of the s	975
	Physici /Medio Examir	cal	Develont's Name (First, Middle, La DONZELL E 4a. Facility Name (If not institution, giv	BROWN Sr	•		4b. City,	Town, or	Location of		2. Date of Month May	Death 28	Day 4c. Co	Year 2005 ounty of Dea	3. Time of 7:40	A M
	Funeral Director		795 Cromwell Drives 5. Social Security Number 6. S 578-60-0312		e (In yrs. la	ast birthday) Yrs.	From If Under Months	eder 1 Year Days	ick If Under Hours	24 Hrs. Min.	8. Date of (Month, Jan.	Birth Day, Y		9. Bin Was	k thplace (State of punity) hington	or Foreign
	D	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Frederic	ek	10c. City	Town or Lo		1				-			10d. Inside Ci	ty Limits
-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "neturel; or Items 23a or 28a-f show event, it a Madical Examit arthurs the notified at	ed by Funeral Director	10e. Street and Number 795 Cromwell Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 11 If Yes, Give Year or Dates:			I□Yes 2	2170 ent of Hiarly Cubar 2∑ No	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or Rican, etc.)	No-	Unit	n of What Co ced St. Race - Ame Black, Whit pecify: Bla of Business.	ates erican Indian, e, etc.	
land 21215-0036	e filed within at Hygiene. other than *	To Be Completed by	(Specify only highest gra Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last, Nathaniel Brown	ade completed) College (1-4or 5	5+)	(Give	kind of wor DO NOT us	k done d	uring mosi	r's Name	ng (First, Mid izabe	Adle, Ma	uto iden Su	mobile	•	
Baltimore, Maryland	permit. Pages 1 and 2 should be lepartment of Health and Mental Importent: If Item 27 is marked of any injury or other traumatic eve angles.		19a. Informant's Name/Relationship (Wife) Removal from State		_	Cromwo sition (Naminatory or of	e 11	nd Numbe	Fror Rura Fr June	Route Nu.	ok,	Md .	fown, State, 2 2170 tion - City or	1 Town, State	
Baltin	permit. F Departme Importer any injur		21. Signature of Funeral Service Licer	Day		10	Name and	d Addres	s of Facilit	DEv	ol Fu r. Ga	nera ith	al H ersh	lome	Md. 208	77
8760,	Provided was executed with burial-transit the burial-transit the burial-transit the burial-transit was a second of the burial-transit the burial-transit was a second of the burial transit the burial transit was a second of the	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each lie a. Metast Due to (or as b. Due to (or as c. Due to (or as d.	atic a consequ a consequ	Prosta ence of): ence of):				cardiac o	Тезрівіої	y arrest			Approximatinterval Bet Queen Que	ween Death
.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pro						230	d. Date of del Month		/ear
0_	The law requires that the tte bas been signed by the bage 2 should be detache	by	Part II. Dther significant conditions of	contributing to death b	ut not resu	lting in the ur	nderlying ca	ause give	n in Part I.				2 [X]		the cause of d	
Vital Records,		e Completed	25. Was case referred to medical								1 ☐ Ye	itopsy irforme s 2/C	d?	24b. Were au prior to death?	topsy findings completion of co	available ause of
Division of Vil	Attending Physici death. ictor: After this cer y the funeral direct	Certification: To Be	examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending investigation 3 Suicide 6 Could not be determined		ry y Yea <i>r)</i> ury - At hor	ER/Outpatien 28b. Time of Injury	M 2	8c. Injury Work 1 🗌 Y	r: 4 □ Nu	rsing Hor	28d. Descrit	esidence be how	injury o		cify) ural Route Num	ber,
۵	Hospite 4 hours Funerel ely filled	edical Cer	29a. Certifier 1 \(\bigcite{\mathbb{N}}\) Certifying Ph (Check only one) 2 \(\bigcite{\mathbb{M}}\) Medicel Exer	nysician: To the best niner: On the basis of and manner sta	of my know f examinati	vledge, death	occurred a	at the tim in my op	e, date ani inion, deat	d place, a	and due to t	he caus	se(s) an	d manner as	stated. to the cause(s)
	To the Complet	Me	29b Signature and title of certifier 30. Name and address of person who	Buth completed cause of d	eath (Item		Print)	D072	285			Ma	ay 3	1, 200		
l	Sta Registr		Dr. James A. Brov 31. Date filed (Month, Day, Year) JUN 01 200	Registra		edical		ter I	Orive	Ro	ckvil	1e,	Md.	20850)	

			1 - For State Registrar	State of Ma	arylan		artment of F		nd Menta	I Hygien Reg. N		
	Physici		Decedent's Name (First, Middle, James	Last) Edwar	-d		В	utler	2. Date Mod May	e of Death	0,2005	3. Time of Death 6
	/Medic Examir		4a. Facility Name (If not institution,				4b. City, Town, o			4	c. County of Dea	alh
			Southern Mary	land Hospi	tal		Clinto	n		Pr	ince G	eorges
	Funeral		Social Security Number	S. Sex 7. Age	e (In yrs. I	ast birthday)	If Under 1 Year Months Days		Hrs. 8. Date Min. (Mo	e of Birth	9. Bir	thplace (State or Foreign ountry)
	Director		214-18-8882 Usual Residence of Decedent	8	34	Yrs.			May	nth, Day, Year 7 26, 1	921 Ma	ryland
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation			<u> </u>		10d. Inside City Limits
	Man B-1 sh	į	Maryland Charl	les	Wai	ldorf						1X Yes 2 No
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28e-f show event, the Medicul Exerting must be notified at	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	ountry?
	ath w		2021 Wedgewood				20604			U	SA	
	er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?			Was Decedent of H f Yes, specify Cub	lispanic Origin an, Mexican, P	? (Specify Ye Puerto Rican, e	s or No- etc.)	14. Race - Am Black, Whi	
50	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	d 1X Yes 2 N If Yes, Give Year or Dates:1		4.5	1 ☐ Yes X ☐ No	Specify:			Specify: Bl	ack
9500-6121	filed within 72 hours after Hygiene. Ither then "natural", or ite ent, the Medical Exercine		15. Decedent's	Education	942-	16a. Dece	dent's Usual Occup	pation		16b.	Kind of Business	
7	thin 7 9.	pie	(Specify only highest : Elementary/Secondary (0-12)	grade completed) College (1-4or 5	+)	(Give life.	kind of work done DO NOT use retire	during most of d)	f working			
N	filed with Hygiene. sther the	Completed	12			Ex	plosive					overnment
Maryland		Be	17. Father's Name (First, Middle, La	st)	_					Middle, Maide		D 13
\leq	s 1 and 2 should f Health and Men item 27 is marke other treumatic	2	James 19a. Informant's Name/Relationship	(Time Scient)	B	utler	ng Address (Street	Netti		Ann		Butler
<u>8</u>	nd 2 silth an 27 is r	1			f	7	-			-		MD 20747
คั	is 1 and of Health item 27 other to	1	Margaret Ford/ 20a. Method of Disposition	Daughter	20b. PI	lace of Dispo	sition (Name of		Date		ocation - City or	
ē	ages ant of nt; If i		1 □ Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe			· .	natory or other place rs Cem.		/6/05			aryland
Baitimor	permit. Pages 1 Department of H Importent; If ite any injury or ot		21. Signature of Funeral Service Lin		DC.		2. Name and Addre		0/03	mai	dorr, M.	aryranu
ñ	Depa Impo any ir		Lley &	25	191	ı A	dams Fu	neral	Home	PA, Aq	uasco.	MD 20608
ľ			23a. Part1. Enter the disease, or conshock, or heart failure. List or	implications that caused	the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	M	ota	1+-+	1 (0)	in C	DUIDE	-		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequ		1 001		317 05			
	LAdillilei	_	Sequentially list conditions,	b			-					
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequ	Jence ot):						
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	a consequ	uence of):						
20	icate be executed physician and s the burial-transit	dicai E		d								
0	The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	a)	_					·				
ž Q	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnancy	,			23d. Date of de	
	e deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at 9 Unknown			Other (specify)				Month	Day Year
r O	d by the	Phy	9 Unknown			- (A)	4 - 14 7	- In Do All	000	Didash		- N
Š	n requires that the de been signed by the s should be detached	by	Part II. Other significant condition	s contributing to death bu	it not resu	liting in the ui	nderlying cause giv	en in Paπ I.	236	1 ☐ Yes 2		o the cause of death?
cords,	regu	eted							_			
Lec	has l	Completed		1					_ 248	autopsy performed?	prior to	utopsy findings available completion of cause of
_	n: The ficate or, page	e Co	25 Mee case referred to medical							performed? Yes 2 N	o 1 Yes	2 No
5	rsician: The law s certificate has t lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	Hospital:	nt 2 🗆 I	ER/Outpatien	t 3 DOA Oth	0.5	Death (Check		6 ☐Other (Spe	
ō	g Phy er this	-	27. Manner of Death	28a. Date of Injur	y	28b. Time of	. 00,00.1	4 🗀 140101		scribe how inju		icity)
0	nding ath. r: Afte	atio	1 Natural 5 Pending 2 Accident investigat	(Month, Day tion	rear)	Injury		k? Yes 2 □ No				
UNISION	er de recto recto	Certification:	3 Suicide 6 Could no 4 Homicide determine		ry - At ho	me, farm, str	eet, factory, office		28f. Loc	ation (Street a	nd Number or R	ural Route Number,
5	itel or ris aft rel Di	Çer		N .								
	To the Mospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying (Check only 2 Medicel Ex	Physician: To the best of taminer: On the basis of and manner state	examinat	wledge, death ion and/or inv	occurred at the tire occurred	ne, date and p pinion, death c	lace, and due occurred at the	to the cause(s time, date an	s) and manner as od place, and due	s stated. a to the cause(s)
	o the	Me	29b. Signature and title of certifier	and marmer star			29c. Licens	e number		29d. Da	ate signed (Mont	h, Day, Year)
	⊢ s ⊢ ŏ		> /1 Vals	in an M	n			2000	2990		4	12005
1	202,1	2	30. Name and address of person wh	MI AU M no completed cause of de	eath (Item	23a) (Type,	Print)		, ,		- 1	1
1	YCIC	1.1	ALI RAHIMIA	am mp	75	101	SURRA	TTJ 8	POAD	CLI	NTON	MD 20735
ı	Sta		31. Date filed (Month, Day, Year)	2 2005 32. Registra	ır's Signat	ture #	hack .					
	Registr	rar	5011 0	~ 2000		10.	Market .					

		State of Maryland / Departmen Certificat	t of Health and Menta e of Death	Reg. No. 2005 1997
	Physician /Medical	Decedent's Name (First, Middle, Last) IZETTA MOSLEY BENSON	MAS	Y 25 2005 8:17 AM
}	Examiner	4e Fecility Neme (If not institution, give street and number) RUXTON NURSING HOME	4b. City, Town, or Location of DENTON	of Deeth 4c. County of Deeth CAROLINE
Ī	Funeral Director	5. Social Security Number 213-22-8536 6. Sex 1 Months 7. Age (In yrs. lest birthday) Months	1 Year If Under 24 Hrs. 8. Date Days Hours Min. (Mo	e of Birth park (State or Foreign Country) 9. Birthplace (State or Foreign Country) P 24, 1905 RIDGELY, MD
	Marylend f show	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location MD CAROLINE RIDGELY		10d. Inside City Limits 1 X Yes 2 □ No
	with the Mar 3a or 28a-f st at be nothing	10e. Street and Number 4 W. 6TH ST PO BOX 45	Code 21660	10g. Citizen of Whet Country?
000	72 hours effer deeth with the Maryland natural; or items 23s or 28s-f show lisst Examiner must be nothing at sted by Furneral Director	If Yes, Give 1 ☐ Yes 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	lent of Hispanic Origin? (Specify Ye cify Cuban, Mexican, Puerto Rican, e Z X No <i>Specify:</i>	s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: BLACK + AMERICAN INDIA
Maryland 21215-0020	d within "i than "c than "comple	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) 6 16a. Decedent's Usu (Give kind of we life. DO NOT u life. DO NOT u	rk done during most of working se retired)	PRODUCE CANNING
land	ould be filed Mentel Hygi mrked other aftic event, I	17. Fether's Neme (First, Middle, Last)		Middle, Maiden Sumame) RICHETT
Mary	12 sh h end r ls m traum			Number, City or Town, State, Zip Code) RIDGELY, MD 21660
Baltimore,	- Se et	20a. Method of Disposition 1	ne of Date	20c. Location - City or Town, State
Balti	permit. Peges Depentment of Important: If I any Injury or once.		d Address of Facility FUNER I DUPONT HWY NEW	RAL HOMES INC CASTLE, DE 19720
	Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mod shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e	e of dying, such es cardiac or respir	ratory arrest, Approximate Interval Between Onset and Death
10	sir ad	Due to (or as a consequence of): b Hypertensu	'M	15 yes
68760, 水	rificate be executed to physician end es the bunel-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of):		V
Box	death cert e ettending ad for use sician/M			
P.O.	ires thet the death certification signed by the ettending dispected for use entire by Physician/M.	Pert II. Other significent conditions contributing to death but not resulting in the underlying of Aortic Stanosis	suse given in Part I. 23	3b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknow
of Vital Records,	been shoul	Palmonary hypertens	in 241	a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?
al Re	: The law cete hes b			1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
f Vit	Physician: The ribis certificate and director, page to Be Co	25. Wes case referred to medical exeminer? 1 Yes Hospital: 1 Inpatient 2 ER/Outpetient 3 DC	26. Place of Death (Check OA Other: 4 Oursing Home 5	k only one) ☐ Residence 6 ☐ Other (Specify)
Division o	or free	27. Menger of Death 1 Netural 5 Pending 2 Accident 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Pleca of Injury - At home, farm, street, factor	8c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Loc	escribe how injury occurred cation (Street and Number or Rural Route Number,
Οį	Atal or Aura efter ral Direction by Certif	4 Homicide determined building, etc. (Specify)	City	y or Town, State)
			in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
Đ	To the com	29b. Signature epertitie of cartifier 29c 29c	D 35 284	29d. Date signed (Month, Dey, Yeer)
	ゆ	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ANDIEM AUDIC IND 219 5	washington.	5/26/05 St Easton mo 2601
*	State Registrar	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) AND BH AUBY M D 219 31. Dete filed (Month, Day, Year) JUN - 1 2005		

DHMH 16 Rev 6/95

GENEVA Briddell

		Please	State of Mary			dealth and Me	•	•
		1 - State Registrar		Ce	rtificate of	Death	Reg.	NO. 2005 19978
Physic /Med		Decedent's Name (First, Middle, La Geneva M. B	riddell				Date of Death Month	Day Year 3. Time of Death 3. S 2005 / 923 M
Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Death	8	4c. County of Death
Funeral Director		219-56-7902		yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye	
and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation	-	•	10d. Inside City Limits
he Mary 28a-f sho	Funeral Director	MD Worces	ter 1	Whaleyvi	T			1√2 Yes 2 □ No
with t	ä	10e. Street and Number 11827 Steam Mill	uill pa		10f. Zip Code 21872)	10g.	Citizen of What Country?
death ms 23	era	11. Marital Status	12. Was Decedent Ever	in U.S. 13.		Hispanic Origin? (Specifian, Mexican, Puerto Ric	ly Yes or No-	U.S. 14. Race - American Indian,
be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or items 23a or 28a-f show event. In Medical Examinational by coulled at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 ☑ No		čan, etc.)	Black, White, etc. Specify: Black
natur rottcal	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup kind of work done	during most of working	16b	. Kind of Business/Industry
withir lene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		<i>DO NDT</i> use retire Assistant	Director		Healthcare
should be filed wat Montal Hygier the marked other the matic event, the	Be C	17. Father's Name (First, Middle, Las	")			18. Mother's Name (F	First, Middle, Maid	
should be and Mental in marked of	TO E	Francis W. Bridd	ell			Martha Bi	riddell	
2 2 2 2 2		19a. Informant's Name/Relationship						y or Town, State, Zip Code)
		Martha Briddell/		Db. Place of Dispo		IIII HIII RO		eyville, MD 21872 Location - City or Town, State
Dearmit. Pages 1 at Department of Hea Importent: If item any injury or other		1 ₩ Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Special	Removal from State	cemetery, crer	matory or other pla	ce)		
permit. Pages Department of Importent: If if any injury or o			nsee		UMC CEME Name and Addre	etery 5/31/2 ess of Facility	2005 W	naleyville, MD
P P P P P P P P P P P P P P P P P P P		23a. Pan1. Enter the disease, or con		ļ I	Lewis N.	Watson Fune		
Physician /Medical Examiner bub/sician and buriar-transit stile pnurar-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord) Due to (or as a cord) Due to (or as a cord)	nsequence of):	HOLY	A Unka	own/	OR1900
ificate g phys		_	_ d					
The law requires that the death certificate the bas been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delivery Month Day Year
igned b	y P	Part II. Other significant conditions		t resulting in the u	nderlying cause giv	ven in Part I.	23a. Did tobacc	o use contribute to the cause of death?
w requires t been signe should be	ted	MALIGNAN	FPERIO	ARU	1115		1 🗆 Yes	2 No 3 Probably 4 Unknown
The law rate has be page 2 sh	Completed by			<u>, </u>			24a. Was an autopsy performed 1 Yes 2	
	BeC	25. Was case referred to medical examiner?				26. Place of Death (C		10 10185 20140
hys this	2	1 ☐ Yes 2 ☑ No		2 ER/Outpatien		4 U Nursing Home	5 🗌 Residence	6 □Other (Specify)
l or Attending P after death. Director: After I I in by the funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	Wor	yat 28d rk? Yes 2 □ No	I. Describe how in	jury occurred
tel or Att s after d el Direct ed in by	Certifle	3 Suicide 6 Could not be 4 Homicide determined		At home, farm, streetify)	eet, factory, office	28f.	Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Exa	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death mination and/or inv	n occurred at the tir vestigation, in my o	me, date and place, and opinion, death occurred a	I due to the cause at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the within To the compl	Ž	29b. Signature and title of certifier J. JA	yler		29c. Licens			Date signed (Month, Day, Year) 5/26/05
		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	salisbung n	20	
-		Jimmy Taylor 31. Date filed (Month, Day, Year)	, M.A. 100	E. CATO	1/ 3/-	Sallsbury "	7/0	
, Sti	ate	MAY 3 1	2005	H. L	barle			

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

05

1 Yes 2 No

Maryland

1832 M

Year

0.5

100 E CATTOIL ST. SALISBUM MO BADros, M.S. JOSEPA 31. Date filed (Month, Day, Year) gistrar's Signature 32. State JUN 0 2 2005 Registrar **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:20 ^{a м} May 29, Marion Lorraine Corrigan 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Hospice-Casey House Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 2 🗗 F 1915 New York 108-03-1718 90 April 17, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Montgomery Olney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 18900 Bloomfield Road 20832 USA Itema 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Peges 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ent: If Item 27 is marked other than "natural", or Item 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 H No Specify: Baltimore, Maryland 21215-0036 þ 3₺ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peter Kaheny Margaret Daley ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Corrigan/ Son 18900 Bloomfield Road, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, Stete 20a. Method of Disposition permit. Peges 1
Department of H
Importent: If ite
any injury or of June 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2005 Silver Spring, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Will 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Intracerebral Hemorrhage 2 Weeks /Medical Due to (or as a consequence of): **Examiner** Hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 28 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice 1 Yes 2 No 2 2 ER/Outpatient 3 DOA his Facility the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c, Injury at Work? Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel C Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D09470 May 30, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10401 Connecticut Avenue, Kensington, MD 20895 Eugene P. Libre, M.D. 31. Date filed (Month, Day, Yeer) 32 Registrar's Signature State DELL JUN 0 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 29, Year **Physician** 2005 Marion Alice Collins 12:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Southern Maryland Hospital Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Director 577-34-1066 1924 Washington DC 80 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other than "natural", or items 23a or 28e-f show vent, the Madical Examiner must be nutified at 1 Tyes 2 No Director Maryland Waldorf Charles 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 3041 Heathcote Road United States 20602 filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Wholesale Elementary/Secondary (0-12) College (1-4or 5+) 12 Purchasing Clerk Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Depertment of Heelth and Mental Hy Importent: if them 27 is marked oth any injury or other treumetic event 2008. Be Ralph Jullian Sandy Mary Marie Maske 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3041 Heathcote Rd., Waldorf, MD 20602 Mary Ann Reynolds-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Barnabas
Episcopal Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) 06-02-2005 Temple Hills, MD 21. Signature of Funeral Service Leep +e 22. Name and Address of Facility Mack A. Wilson M01246 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ponsequence or Examiner the attending physicien and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tive of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52289 5/29/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 St. Patrick's Dr., Suite 404, Waldorf, MD 20603 Nalin Mathur, MD_ 31. Date filed (Month, Day, Year) State Registrar JUN 0 1 2005

	1 - For	a istrar			State of	marylar	nd / Dep <i>Ce</i>	artme <i>rtifica</i>				mentai r				
			e (First, Middle	Last)			- 00	Tunca	10 01	Dea	ui	2. Date of	Reg.	No.		3. Time of Death
Physician		Harve	ey Edwa	rd	Charlto	n Ir						Month May		2005	Year	1 1 7 9 8
/Medical Examiner	4		f not institution,				•	4b. City	y, Town, o	or Locat	ion of Deat		20,	4c. County	y of Death	0442 A
		Cono	wingo I	Road				Cond	owing	80				Cecil		
Funeral	5. Social	Security N	umber	6. Sex			last birthday 45 Yrs.		er 1 Year	If Un	ider 24 Hrs irs Min.	(Month	Birth Day, Ye	ar)		place (State or Foreig
Director		-72-37 esidence of		1 22			45 Yrs.					March	27,	1960	Mar	yĺand
Mo ma	10a. Sta		10b. County			10c. C	ity, Town or L	ocation								10d. Inside City Limit
Depotation of results and worked or trygency. Depotation: If them 27 is marked or then than "natural; or theme 23a or 28e-f show any injury or other traumatic event, the Mudical Examinat must be notified at once. To Be Commissed by Funeral Director	Mary	land	Ceci	1		C	onowin	0.0								1 ☐ Yes 2 🛣 N
Director.	10e. Stre	et and Nun	mber		-				ip Code				10g.	Citizen of	What Co.	intry?
dian in	1144	Rock	k Sprin					2	21918	3			Un	ited	Stat	es
9	11. Marit	al Status			Was Deced Armed Ford	es?	J.S. 13.	Was Deci	edent of i	Hispanic Dan, Mex	Origin? (S	pecify Yes or to Rican, etc.	No-		ce - Amer	ican Indian, , etc.
hy Eunerai	3 🗆		ed 2 Marri 4 ⊠Divorced	ed	1 Yes 2 If Yes, Give Year or Dat	! □ No es:		1 🗆 Yes	2 X) No	Spe	city:			Specif	y:Whi	te
			15. Decedent	s Educ	ation		16a. Dece	edent's Us	ual Occur	pation			16b	. Kind of B	usiness/l	ndustry
j	Fleme		ify only highes ndary (0-12)	t grade	Completed)	4or 5+1	(Give	DO NOT	vork done use retire	during i ed)	most of wo	rking				,
Completed		12					True	ck Dr	iver	•			T	ransp	orta	tion
a	17. Fath	er's Name ((First, Middle, l	.ast)								ne (First, Mic			ne)	
٢			Edward			Sr.				1		Ann Sl				
			ame/Relationsh		-							ıral Route Nu				
		Lma A	Ann Del	p/mo	other	20b.	Place of Dien	neition /N	ama of		1	dising Date	000	1 acation	Other day 7	The Charles
	1 X	Burial 2	☐ Cremation		moval from Si	tate Ne	cemetery, cre w Brid	matory or ge Ce	other pla	ece) 2 r v	June	2,200	5 Ri	sing	Sun.	Maryland
			5 Other (Spineral Service L								1					
any ir	()	12	1 0	0	Cla	مأكم		111 0		0	R.	Foan	rd Fu	inera.	1 Hor	ne, P.A.
attending physician and for use as the burial-transit	resulting	tially list cor sading to im Enter Unde Disease or ated events in death) L	j	b. c.	Due to (o	r as a consecrate as a consecr	quence of):									
as the				d.				_								
hy Physician/Medica	IF FEM 23b. Wa in t 1 C 9 C	ALE: is decedent he past 12 Yes 2 [Unknown	months? □No	23		th 2 ☐ Fet nt at time of	al death 3	□Ectopic □ Other (s		су			-		ite of deliventh	rery Day Year
2	Part II. C	ther signif	icant conditio	ns cont	ributing to dea	th but not re	sulting in the	underlying	cause gr	ven in P	art I.	23e. D	id tobacc	o use con	tnbute to	the cause of death?
						· .						1	Yes	2 🛚 No	3 🔲 Pro	bably 4 □Unknow
Completed												24a. W	utopsy			opsy findings availab
5												1 X Y	erformed s 2 🗆		death? 1 X Yes	2 No
å	өхаг	niner?	red to medical	H	ospital:				04		lace of Dea	ath (Check or	ly one)			
Jon. To Be	1 X	Yes 2 🗌		"	1 □ In		ER/Outpatie		JOA		Nursing F	lome 5 R				fy) at scene
Certification.	1 🗆	Natural Accident	5 Pending		Z	, Day Year)	Injury	AM	28c. Inju Wo 1	ork?]Yes 2	2 (XNo		dest	vian	3,1	uck by
ific	3 🗆	Suicide	6 Could n	ot be	28e. Place o	105 of Injury - At h	nome, farm, si	treet, facto				28f. Locatio	n (Street	and Numb	per or Rui	al Route Number,
t	ول ۵	Homicide			pullaine	g, etc. (Speci Paul C		ot				4	Town, St	1 0	O Con	owing o Rd
1	29a. Ce		1 Certifying	Physi xamin	ician: To the b	est of my kn	owledge, dea	th occurre	d at the ti	ime, date	e and place	and due to	the cause	a(s) and ma	anner as	stated.
ply filled	1 (C)				and manne	or stated.	210114114011					11100 21 1110 111	-			
ladicai C	(CI or							29	9c. Licen:	se numb	oer		29d.	Date signe	d (Month,	Day, Year)
Modical	29b. Sig	nature and	title of certifier	G 4	la m		11. 1	-	OCI	ME.						
Completely filled in by the lu	•		ess of person v	et	talle	an	wd		OCI	ME ——			Mar	y 28,	200	5

				1 - For State Registrer	State of Ma				Health a f Death	nd Me		giene	05	19983
		Physic		1. Decedent's Name (First, Middle, Last) Marie T. Covingto	on					:	2. Date of Dea		2005	3. Time of Death 07.50 M
		/Medi Examir		4a. Facility Name (If not institution, give s		al Can b	41	o. City, Town	, or Location of	Death	03	4c. Cou	nty of Death	l
		Funeral Director		5. Social Security Number 6. Sex 217-42-6022	M 2 F 62	(In yrs. last birti		Under 1 Year onths Day		Min.	B. Date of Birth (Month, Day 2–25–43	Year)	9. Birthp Count Md •	lace (State or Foreign try)
				Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locati	on						0d. Inside City Limits
		h the Mar r 28e-f s	Director	Md. Wicomico 10e. Street and Number		Parsons		3 10f. Zip Code)			10g. Citizen	of What Coun	1 ☐ Yes 2 🔀 No
		23e c	al D	31615 Zion Road				21849	9			USA		
	336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "netural", or Items 23e or 28e-f show eny injury or other traumatic avant, Ital Mardical Exam and must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1		f Hispanic Orig uban, Mexican, o Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)		lace - Americ Black, White, cify: Whi	etc.
	Baltimore, Maryland 21215-0036	thin 72 hou e. an "neture Medical E	Completed	15. Decedent's Educ (Specify only highest grade	ation		Decedent (Give kind life. DO	's Usual Occ d of work don NOT use reti	upation ne during most red)	of working	9	16b. Kind of	Business/Ind	
	21	ygiene ygiene her tha	Соп	12			Hon	nemake	1			Но		
	land	ild be fil lental H ked oth	To Be	17. Father's Name (First, Middle, Last) Francis Tribbitt							^{First, Middle, 1} lark Tr		,	
	lary	2 shou and M is mar	-	19a. Informant's Name/Relationship (Typ	e, Print)				et and Number					Code)
	e,	1 and 1 Health Im 27 Ther tri		Alfred B. Covington 20a. Method of Disposition	n, Husban				d. Pars					
	mor	bages ent of th nt: if Ita y or of		1 ☑XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of cemetery			1 .	Da		Delma	n - City or To	wn, State
	altii	permit. P Departm Importar eny injur		21. Signature of Funeral Service License	9		22. Na	ame and Add	ress of Facility			DCIMA	i, be.	
		20599		23a. Part1. Enter de disease, or complic	Dewel	L Date	13	E. Gro	ove St.	_Deli	mar. De	.1994	00	
		Pnysician		Immediate Cause (Final	cause on each line	э.				ardiac or i	respiratory arr	est,		Approximate Interval Between Onset and Death
		/Medical		disease or condition resulting in death)	Due to (or as a	consequence o	f):	~0	Lorga					3 years
7		Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	consequence o	f):							
2602	8760,	certificate be executed ding physician and ise as the burial-transit	dical Examiner	Causa (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	f):							
217-4	O. Box 68	that the death certifica led by the attending pt detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Vio 9 □ Unknown	c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death		opic pregnan ner (specify)	су				Date of deliver	ry Day Year
ton	ords, P.	sign d be	by	Part II. Other significant conditions cont	ributing to death but	t not resulting in	the under	lying cause g	pven in Part I.			pacco use co		e cause of death?
ving	Rec	The law ate has b page 2 st	Completed							_	24a. Was a autops perform	v	o. Were autop prior to con death? 1 \(\sum \text{Yes} \)	sy findings available apletion of cause of
60	Vital		o Be	25. Was case referred to medical examiner?	spital:			_ 0			Check only on			
G.	of	g Phys er this ieral di	-	27. Manner of Death	28a. Date of Injury (Month, Day		me of	28c. Inj	ther: 4 Nurs		 5 Reside Describe ho)
ar	Division	Attending F r death. actor: After by the funer	icatlo	1 Accident 3 Suicide 5 Pending investigation 6 Could not be				M 1[JYes 2□No					
1	Div	To the Hospital or Attending Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification:	4 Homicide determined	28e. Place of Injur building, etc.						City or Town	i, State)		Route Number,
		e Hosp 124 hou a Funal letely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physi 2 Medical Examine	cian: To the best of er: On the basis of e and manner state	examination and	death occi /or investi	curred at the gation, in my	time, date and opinion, death	place, and occurred	d due to the ca at the time, da	ause(s) and rate and place	manner as sta e, and due to	ited. the cause(s)
		To the within 2 To tha complet	Me	29b. Signature and time of certifier	7 - 1	u. 2.			nse number				ned (Month, D	* * * * * * * * * * * * * * * * * * * *
	,	S.		1/10/-					3069	ري '		May	28,	2005
		1/2		30. Name and address of person who com					0/1 57		5. 152	600=	MD	21801
		Sta	- 24	31. Date filed (Month, Day, Year) 1 20		's Signature	1	- M		- / -	1.3	7.		- 10-1
		Registr	ar	INITIO T ZO	THE PARTY	e to	SOM	ule)						

			For	State of Ma			lealth and Mo	ental Hygie	ne	
			Registrar 1. Decedent's Name (First, Middle, La	st)		ertificate of		Reg. 2. Date of Death	No.	3. Time of Death
	Physicia /Medic Examin	al	MARY EUZ 4a. Facility Name (If not institution, give	ABETH	CANK		or Location of Death		Day Year 200 5	5.00A M
	Funeral	er	5. Social Security Number 6.5	ehaba, r. Age	14 RS. C	SALI'S	bURY	8. Date of Birth (Month, Day, Ye	Wico	thplace (State or Foreign
	Director		Usual Residence of Decedent	□ M 2 DTF	8.8 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	17 Co	MD
	Be-f show	Director		MICO	10c. City, Town or L	DEN				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the	ral Dire	31203 - EDEN	ALLEN	Ro		822		Citizen of What Co	7
36	rs after de	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cub:	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
NON Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-1 show or other traumatic event, Ire Madical Eraculaer traumatic event, Ire Madical Eraculaer traumatic event.	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	pation during most of working d)	g 16b	o. Kind of Business/	
121	filed with Hygiene. other ther	Con	7 17. Father's Name (First, Middle, Last			LABORE		First Middle Mai	ARM S	
and	buld be f Mental F arked ot atic ever	To Be	CHARLES	\	BLE		18. Mother's Name	(First, Middle, Maid	ien Sumame)	
ary	2 should be and Mental is marked (sammatic ev	-	19a. Informant's Name/Relationship (ling Address (Street	and Number or Rural	Route Number, Ci	ty or Town, State, 2	Zip Code)
	Pages 1 and 2 nent of Health int: if item 27 ary or other tra		DOROTHY BARKU 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐		20b. Place of Disp cemetery, cre	matory or other place	Da		EN MD. Location - City or	2 8 12 Town, State
MARY CAN	permit. Pages Department of Important: If is any injury or o		21. Signature of Funeral Service Lice		ST MAR	YS CH. C	EM. 6/4	NNIE S	Smith F	EFRE, MD
~ 0	99 5 5		Musulla	Kninde) (717WIS	SABELLA S	ST. SAUS	BURY, MI	
o	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	xiz .	nter the mode of dyir	ng, such as cardiac or	respiratory arrest,	,	Approximate Interval Between Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	b. Respr	consequence of):	Mure				hours
°.	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	c. longer	consequence of):	east far	Ture			years
68760,	ificate be g physicia as the bur	edical		_ d.						
Division of Vital Records, P.O. Box	To the hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of deli Month	very Day Year
ords, P	w requires that been signed b should be deta		Part II. Other significant conditions of	ontributing to death but	not resulting in the i	underlying cause giv	en in Part I.		co use contribute to	the cause of death?
II Reco	The law recate has be page 2 sho	Completed						24a. Was an autopsy performed 1 Yes 2 X	prior to death?	topsy findings available completion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	-5	oth Oth	26. Place of Death (
on of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ıtlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigatio	1 ∐ Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatie 28b. Time of Injury	of 28c. Injur	4 Nursing Home	e 5 Residence id. Describe how in	6 ☐ Other (Special of the following occurred)	ify)
Divisi	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined		r - At home, farm, st (Specify)	treet, factory, office	28	f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital within 24 hours of the Funeral completely filled	edical	29a. Certifier Check only one) Certifying Property 2 Medical Example 1	ysician: To the best of niner: On the basis of e and manner state	xamination and/or ir	th occurred at the tin	ne, date and place, an pinion, death occurred	d due to the cause I at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
•	To the To the comp	Me	29b. Signature and title of certifier	Wy pr	0	29c. Licensi	775933		Date signed (Month)	
F 1	60		30. Name and address of person who	1 owe	th (Item 23a) (Type	610 Du	Ichm L	ane E	aspor 1	1) 21601
	Stat Registra		31. Date filed (Month, Day Year) 2	2005 32. Figistrar	s Signature	porte			,	

Richard Elias 05-03965 NJM

[1 - For Unpend Ite	m 23a,27,28a-f per	Department of H me G844 6-30 Certificate of L	ealth and Me P05 tas Death	ental Hygiei Reg.	ne 2005	19985
Physician	1. Decedent's Name (First, Middle,	Last)			2. Date of Death		3. Time of Death
/Medical	Richard Allen El				June	9 2005	1626 M
Examiner		give street and number)		Location of Death		4c. County of Death	
7	Union Hospital 5. Social Security Number	6. Sex 7. Age (In yrs. last b.	Elkton	If Under 24 Hrs.	2 Data of Bigh	Cecil	
Funeral Director	184 50 8774 Usual Residence of Decedent	X M 2 □ F 48	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye. June 18,1	ar) Cou	place (State or Foreign ntry) Sylvania
yland	10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits
a-f el	Maryland Cecil	North	Fact				1 XYes 2 No
with the Mar s or 28a-f el Le nydiffed Director	10e. Street and Number	HOLCH	10f. Zip Code		10g.	Citizen of What Cour	ntry?
ath w	108 Beech street		21901		Un	ited Stat	es ·
is 1 and 2 should be filed within 72 hours after death with the Maryland of the all nand Mental Hygiene. If health and Mental Hygiene, the marked other then "naturel; or Items 23s or 28s-f ehow other treumatic event, Ite Medical Examinational Le modified at To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, ② No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec i, Mexican, Puerto Ri Specify:	ity Voc or No	14. Race - Americ Black, White, Specify: Whi	can Indian, etc.
in 21215-0036 led within 72 hours att vigene. Tratural; or the then Tratural; or the then Tratural Example Completed by F	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)	uring most of working	16b.	Kind of Business/In	dustry
e filed other went.	12 17. Father's Name (First, Middle, Li		<u>chine Operato</u>	or 18. Mother's Name (mber	
Maryland d 2 should be file th and Mental Hy 27 Is marked oth treumatic event To Be (Frances Ha		en Sumame)	
should and Men of Merke umatic	19a. Informant's Name/Relationshi		b. Mailing Address (Street a			v or Town State Zin	(Codo)
Mand 2 anth a aith a saith a sr tree	Frances Dammann/		08 Beech Stre				
Baltimore, Ma permit. Pages 1 and 2. Department of Health at Important: If tien 27 le any injury or other treu-	20a. Method of Disposition	20b. Place of	of Disposition (Name of ery, crematory or other place	Dat		Location - City or To	
Page Page nent of ant: If	1 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe		ary Anne's	2005	150	th East,Ma	reset - out
salt ermit. spart poorts by inju	21. Signature duning S. met	ense	22. Name and Address		uch Fune:	ral Home	aryland
o ggiga	1/lhoten		127 South N	lain Stree	t,North	East,Mary	land 21901
Hnysician /Medical Examiner	23a. Part Letter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	a. Asphyxia Due to (or as a consequence		such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
*	Sequentially list conditions,	b. Drowning					
ted nsit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University of the cause of a years.	Due to (or as a consequence	of):				
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner.	that initiated events resulting in death) Last	c	of):				
Box 6(Box exitic Bath certific attending pi for use as i	IF FEMALE:	23c. If yes, outcome of pregnancy					
P.O. Box that the death cert ed by the attending detached for use.	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ry Day Year
cords, F w requires that been signed should be de	raith. Other significant conditions	s contributing to death but not resulting in	n the underlying cause given	in Part I.	23e. Did tobacco	use contribute to th	
	25. Was case referred to medical				24a. Was an autopsy performed? 1 X Yes 2 □ N	prior to con death?	psy findings available inpletion of cause of 2 No
Vision of Vital Attanding Physicien: Geath. ector: After this certifica by the funeral director, to	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 XER/Ou	Other	26. Place of Death (C			-
n of g Phy ter thii heral o	27. Manner of Death	28a. Date of Injury 28b. 1	Time of 28c. Injury a	4 Nursing Home	5 Residence J. Describe how inju	6 □Other (Specify,)
Division c teel or Attending P is after death. al Director: After led in by the funera Certification;	1 □Natural 5 □ Pending 2 Naccident investigat	(Month, Day Year) Fou		s 2 No Su			mming pool
Divisic of or Attend after death I Director; of in by the f	3 Suicide 6 Could not 4 Homicide determine	be 200 Diago of Injury At home to		28f.	Location (Street a	and Number or Rural	Route Number,
Divine atternation or state or ral Dir led in Cent		Swimming pool a	t private dwe	elling No	rth East.	25 Beech Cecil Co	ounty, MD
Divis To the Hospitel or Att within 24 hours after de To the Funeral Direct completely filled in by t Medical Certiffic	29a. Certifier 1 ☐ Certifying 1 (Check only one) 2 ☑ Medical Ex	Physician: To the best of my knowledge aminer: On the basis of examination and and manner stated.	e, death occurred at the time, d/or investigation, in my opin	date and place and	I due to the enuse	a) ===d ================================	4-4
To the within To the composition	29b. Signature and title of certifier	An M	29c. License r			ate signed (Month, D	
	5.K. H	o completed cause of death (Item 23a) (Type, Print) 111 Penn	Street Ba		Maryland	
State Registrar	31. Date filed (Month, Day, Year)	33 Registrar's Signature	Courte				

			1 - For Stata Registrar	State of Mar			lealth and	Mental Hy	giene Reg. No. 20()5 19984
	Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last EVELYN 4a. Facility Name (If not institution, give REBECCA HOU	S. EICI	HBERG	4b. City, Town, (or Location of Dea			
	Funeral Director		5 Social Security Number 6 Se		iln yrs. last birthday 91 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h 9	Birthplace (State or Foreign Country) WASHINGTON, D
	be filed within 72 hours after death with the Maryland stal Hygiene. do other than "natural" or frams 23a or 28a-f show avant, the Medical Evanting mines to recitive and	Funeral Director	10a. State 10b. County FLORIDA BROWARD 10e. Street and Number 1662 S. OCEAN La		Oc. City, Town or L ${ m FT}$.	LAUDERDA 10f. Zip Code	LE 3316		10g. Citizen of Wha	10d. Inside City Limits 1
9800	hours after deal lural: or flams	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1☐ Yes 2☒ No	Specify:	Specify Yes or No- to Rican, etc.)	Specify:	American Indian, Vhite, etc. WHITE
Maryland 21215-0036	filed within Hygiene. Thar than " nt, the We	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give	edent's Usual Occup b kind of work done DO NOT use retire MEMAKER	during most of wo	orking me (First, Middle,	OWN H	,
aryian	should be and Mental I is marked o	To Be	LEONARD B. SCI	pe, Print)	19b. Mail	ing Address (Street	GERT	CRUDE M.	MOSES	te, Zip Code)
Baltimore, M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury oc. other traumatic anonce.		JOHN A. EICHBERG — 20a. Method of Disposition 1 Burial 2 □ Cremation 3 From the Companion 1 Companion 2 From the Companion 3	emoval from State	20b. Place of Disp cemetery, cre		ce)	Date	MD 20815 20c. Location - City WASHINGT	or Town, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	90	Ĕ 1	DWARD SAG 091 ROCKV	EL FÜNER ILLE PIK	AL DIREC	TION, INC	20852
	Inysician /Medical Examiner		23a. Part Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		SON'S DI		ig, such as cardia	c or respiratory an	est,	Approximate Interval Between Onset and Death YEARS
	* *	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease of injury that initiated events resulting in death) Last	Due to (or as a c						
P.O. BOX 00	w requires that the death certifics been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of Month	delivery Day Year
L (Sp. L	equires that en signed by ould be deta	by	Part II. Dther significant conditions cor CEREBROVASCULAR		not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to		e to the cause of death?
lai necords,	ysician: The law r is certificate has be director, page 2 sh	e Completed	25. Was case referred to medical					24a. Was a autops perfor 1 ☐ Yes	prior death	autopsy findings available to completion of cause of ?? /es 2 \(\) No
DIVISION OF VITAR	ding Ph h. After th funeral	Certification; To B	examiner? 1 Yes 2 No Feeding 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1	- At home, farm, st	of 28c. Injur Wor M 1	er: 4X Nursing H	28d. Describe ho	ence 6 Other (Sow injury occurred	Specify) Rural Route Number,
5	To tha Hospital or Attan within 24 hours after deal To tha Funaral Diractor: completely filled in by the		29a. Certifier (Check only 2 Medical Examin	building, etc. (ician: To the best of mer: On the basis of ex	Specify) ny knowledge, deat amination and/or in	h occurred at the tin	ne, date and place	City or Town	n, State)	as stated
	To that within 2-	Medical	29b. Signature and title of certifier	Steve W	-D	29c. Licens			9d. Date signed (Mo	onth, Day, Year)
6	Sta Registr		30. Name and address of person who con ALAN W. STONE, M. 31. Date filed (Month, Day, Year)		STREET,	,	E 404, W	ASHINGTO	N, DC 200	06

				Type or Print State of Mar				-		egible.	
			1 - For State Registrar	otato or mai		rtificate of			Reg. Nó,	nns	10007
	Physici /Medio		1. Decedent's Name <i>(First, Middle, L</i> as Marga	•	hrlich			2. Date of Dea Month May	Day 26,	Year 200:	3. Time of Death 2:30am 11:55 P. M
1	Examin		4a. Facility Name (If not institution, give		10/		or Location of Death		3.5	ounty of Dea	
	Funeral		15101 Interlache 5. Social Security Number 6. Se		IU4 In yrs. last birthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birt	h MO	ntgom	ery thplace (State or Foreign
	Director			□M 2QF	80 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Sept.	19, 1	.924 i	New York
	inylanc ihow	_	10a. State 10b. County		0c. City, Town or Lo						10d. Inside City Limits
	he Ma 28a-f	Directo	Maryland Montgom	ery	Silver						1 ∑Yes 2 □ No
	3e or		10e. Street and Number	D # 1	0.4	10f. Zip Code		55		en of What C	ountry?
	me 2	Funerai	15101 Interlachen	12. Was Decedent Eve		Was Decedent of I) Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-			encan Indian,
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or iteme 23e or 28a-f show event. If a Madical Examiner must be notified at	by	1 □ Never Married 2 □ ★ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Hican, etc.)		Black, Whi pecify:	White
215-0036	hin 72 ho e. en "netur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worki	ng	16b. Kind	of Business	/Industry
21	filed with Hygiene. other ther			College (1-4or 5+) 2 Years	Sec	retary	1				vernment
\subseteq	e d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden St	u <i>rname)</i>	
2	d 2 should be I th and Mental I 7 le marked o traumatic eve	2	Charles Sharke	/	19b. Mailir	na Address (Street		Ajia I Route Numbe	r. City or 7	Town State	Zip Code) 20906
	rai		Jack A. Ehrlich	- Husband			chen Dr.,				
Baltimore,	8 0		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei			ate		ation - City or	
Ě	Pages Iment of I tent: If it		`4 □Donation 5 □ Other (Specify		Parklawn	Menorah	Gdns 5/29	/2005	Rockv	ille,	Maryland
g R	Department of Importent: If any injury or once		21. Signature of Funeral Service Licen	7		2. Name and Addre		l Direc	tion.	Inc.	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	plications that caused the			sel Funera ville Pike ng, such as cardiac o			, Mary	Approximate Interval Between Onset and Death
	Prrysician /Medical		disease or condition resulting in death)	aCorons Due to (or as a corons	ry Artery	Disease					3 Years
	Examiner		Sequentially list conditions		lipidemia						10 Years
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):						
20	e be e rsician e buria	SaiE		d							
9	tificate ig phy as the	ledic									
ROX	eath certificate be executed attending physician and for use as the burial-transit	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [Ectopic pregnanc	v		230	d. Date of de	,
	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Physician/Medi	1 Yes 2 No	4☐ Pregnant at tim 9☐ Unknown	ne of death 5	Other (specify) _				Month	Day Year
Ž.	ires that the de signed by the a I be detached f	by Ph	Part II. Other significant conditions co	ontributing to death but r	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
ras	w requires been sign should be							1 □ Y	es 2 🗆 1	No 3∏P	obabiy 4 Hunknown
Vital Records,	law reas bei	ompleted			_			24a. Was a		24b. Were at	utopsy findings available completion of cause of
E E	eician: The law certificate has b irector, page 2 s	Con						perfor 1 ☐ Yes	med?	death? 1 ☐ Yes	
	Phyeician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:	a [] EB/O	. all post lott	26. Place of Death				
n or	Phy this ral d	-	1 ¬Yes 2 □ No 27. Manner of Death 1 ¬YNatural 5 □ Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	I 3LI DOA	4 Nursing Hon	8d. Describe h			cify)
20	tendii Jeath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No				
DIVISION	after of Direct of In Direct of	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (eet, factory, office	2	t8f. Location (S City or Tow		Vumber or Ri	ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funerel or	edical C	29a, Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	n occurred at the time vestigation, in my o	me, date and place, a opinion, death occurre	nd due to the cod at the time, o	ause(s) an late and pl	nd manner as lace, and due	s stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date s	signed (Mont	h, Day, Year)
	17		Darl	Celon	Lun	D23	3805		May 2	26, 20	05
			30. Name and address of person who o				D 1 " 0	15 6:1		7	M4 20010
		ta	Daniel I. Worono 31. Date filed (Month, Day, Year)				koad, # 2	15, 811	ver S	pring	, Md 20910
	Sta Registr		denote a de al	305 Finere	Signature	and					

			1- State of Maryland / Department of Health and Certificate of Death		ene 005	19988
	°. Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month MAY 29	Day Year	3. Time of Death
	/Medic	al	DONALD E. FRAZIER, SR 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of Dear	1400 M
	Examin	er	Shady Grove Adventist Hospital Rockvill]	MONTGON	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hours Norths Days Hours N	Ain. (Month, Day, Y	ear) 9. Birt	hplace (State or Foreign
	Director		214-42-6174 1XM 2□F 61 Yrs. Monins Days Hours W	Apr.7,	1944 Ma	arýland
	show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
:	a-fsh	tor	MD Montgomery Gaithersburg	<u> </u>		1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	ountry?
-	s 23a	sral	9531 Brink Road 20882 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	U.S.A.	ncan Indian
	ritem	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Pt	uerto Rican, etc.)	Black, Whit	e, etc.
ž	illed within 72 hours after death with the Maryland Hygiene. Hydiene. Hydiene in atturel', or Items 23a or 28a-f show ont, the Medical Examinat must be notified at	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: B	Lack
5	"natu	letec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	working 16	b. Kind of Business	Industry
4	withir iene. than	Completed	Elementary/Secondary (0-12) 12th College (1-4or 5+) Horticulturist	I	City of	Rockville
2	ould be filed within 72 hours after death with the Maryla Mental Hygiene. A retked other than "natural", or Items 23a or 28a-f show attic event, the Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle, Ma		
7.0	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Mi	To		nese Clag		
_	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Juanita E. Frazier (Wife) 9531 Brink Road,			
	of Health litem 27 I		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or	
2 .	Sent of Sent o		128Burial 2 Cremation 3 Hemoval from State Brooke Grove Cem 6/	4/05 G	aithers	ourg, MD
Dali	permit. Pages I Department of H Importent: If ite any injury or of once.		21. Signature of Funeral Service Licenses 22. Name and Address of Facility 24.6 N. Wash. S	t., Rockv	UNERAL I ille, MI	20850
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care			Approximate Interval Between
F	hysician		shock, or heart taffufe. List only one cause on each line. Immediate Cause (Final disease or condition Section Size 1.5 C. S.			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			·
ľ	_xammer	J.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			1 month
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events C.			
5	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
2 .	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	dlcal	d			
) (he death certifica r the attending phy ched for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of de	ivery
<u>.</u>	death e atter d for u	Iclar	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
2	res that the de signed by the a be detached to	Phys	9 Unknown	22a Did taba	an una contributa te	the cause of death?
ה מ	ries th signed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			obably 4 Unknown
5	w requir been si should l	letec	Dog hall and alliha	24a. Was an	24b. Were au	itopsy findings available
ב ב	scertificate has birector, page 2 s	Completed	TO LEGISLEY YULLESTON	— autopsy performe	d? death?	completion of cause of
2	ding Physicien: The h.	BeC	25. Was case referred to medical examiner?	Death (Check only one)	(no)	
5	hysic this ce al dire	ဥ	1 Yes 2 No Hospital: 11 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	g Home 5 Residence		cify)
5	of the land	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe flow	injury occurred	
	Atten r deat ector; by the	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Ri	ural Route Number,
5	tal or rs afte el Dir	Cert	Dullding, etc. (apacity)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the death occurred at the date of the death occurred at the time, date and place of the death occurred at the time, date and place of the death occurred at the date of the date of the death occurred at the date of the date occurred at the date	lace, and due to the caus occurred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	Fo the within Fo the comple	Mec	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Mont	h, Day, Year)
	10		1 mendleuglown D3824	62 1	nay 3	0,2005
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pro 0 101 FND H (2 H) TT 1 2401 Rex	enal ali	in Such	0 330
	Sta	to		SCATCO DE	TI) RE	Jule M
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 2005 32. Begistrar's Signature			

			For State Registrar	State of Mai		artment of F		•	giene Reg. No.20	05 1998	39
	D1		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	aath Day	3. Time of Dea	ith
	Physici /Medi		Lucille	Morton	Forbri	lch		May		2005 9:55 P.	М
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	th	4c. County	of Death	
			Shady Grove Adven	tist Hospi	ital	Roc	kville		Mont	gomery	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs			Birthplace (State or For Country)	reign
	Director		297-01-9381]M 2 X F	93 Yrs.	Months Days	Hours Min	April	13,1912	Ohio	
			Usual Residence of Decedent			<u> </u>				OHIO	
	ehow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Li	mits
	Mar	호	Maryland Montgom	ATV	Germant	-own				1 □ Yes 2 🔀	No
	28a	Funeral Director	10e. Street and Number	CLY	OCLIMATIO	10f. Zip Code			10g. Citizen of V	Vhat Country?	
	with with		20700 Spinning Who	o1 D1000		208	7.6		United	States	
	eath	era	20709 Spinning Whe	12. Was Decedent Ev	ver in U.S. 13.			Specify Yes or No		e - American Indian,	
	itan Itan	5	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🕱 No	, , , , , , , , , , , , , , , , , , , ,	Was Decedent of H If Yes, specify Cub	an, Mexican, Pue	nto Rican, etc.)	Blac	k, White, etc.	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or itams 23e or 28e-f ehow the Modical Examiter must be motified at	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	´	1 ☐ Yes 2 🛣 No	Specify:		Specify		
Ş	hour	D D			16a Dace	edent's Usual Occup	nation		16b. Kind of Bu	White	
5	"na"	Completed	15. Decedent's Edu (Specify onfy highest grad	e completed)	(Give	kind of work done DO NOT use retire	during most of we	orking	160. Kind of Bu	siness/industry	
2	ight de la la la la la la la la la la la la la	E	Elementary/Secondary (0-12)	College (1-4or 5+)		۵)		TY	_	
7	filed withit Hyglene, other then		47 Fabrus North (First Middle Spec)	4	но	usewife	40. Mathada Na	- /Fire Adiable	Home		
n		Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ime (<i>First, Middl</i> e	, Maiden Sumam	θ)	
<u>×</u>	ould be Mental I wrked o	၉		forton				Wilhel	mina	Reich	
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Itam 27 is marked or any nitury or pher traumatic every orpes.		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ing Address (Street	and Number or F	iural Route Numb	er, City or Town,	State, Zip Code)	
Σ	alth 127 er tr		Louis R. Forbrich,	Jr./Son	20709	Spinning	g Wheel	Place, G	ermantow	m, MD. 20874	ŀ
re	transition of the		20a. Method of Disposition		20b. Place of Disponent	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or Town, State	
Baltimore,	en de de de de de de de de de de de de de	1/1	1 XBurial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)		Jefferson	-		3 2005	Dittabi	uroh DA	
₫	in the rate of the		21. Signature of Funeral Service Ligens	99. 0		2. Name and Addre		The state of the s			_
Ba	Dep mb	-		10.00	/ 0						7
			23a. Part1. Enter the disease, or complete	institute that sourced the						rg, MD. 2087	
			shock, or heart failure. List only o	ne cause on each line	i.	ter the mode of dyir	ig, such as cardia	ic or respiratory a	rrest,	Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition		Seis	25				3 d C 1	10
	/Medical		resulting in death)	Due to (or as a	consequence f):						
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	uted d ansit	Examiner	Cause (Disease or injury	c							
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87	physicate by the b			1.							
9 X	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pragnancy				0015		
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnancy	4		23d. Date Mor	e of delivery oth Day Year	
	he a	Si	1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at til 9 ☐ Unknown	me of death 5L	Other (specify)				,	
О. О.	by the	Š.	9 🗆 Unknown								
	res that the de signed by the a be detached t	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	Inderlying cause giv	ren in Part I.	23e. Did t	obacco use contri	ibute to the cause of death	?
ë	quire in sig		acute	Myoci	andio	il cu	Larc	10°	Yes 2 No	3 Probably 4 □Unkno	own
Records,	w requ	Completed	ORCALZA	100	200	10,01	me.	24a. Was	an 24b. V	Vere autopsy findings availa	able
Re	has ge 2	E	0.00	1	100	1)		autor	osy pormed? d	rior to completion of cause leath?	of
_ 			coan	lopa	1 che	/		1 ☐ Yes	2 No 1	Yes 2 No	
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o	one)		
of	Physi this al dir	P	TES ZE NO	1mpatient			4 🗀 Nursing	-	dence 6 □Othe		
	ding P h, After t funera	ü	27. Manner of Death 1 ⊕Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of 28c. Injur Wor	y at rk?	28d. Describe	how injury occurre	bd	
0	or Attanding after death. Director: After in by the fune	at	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Division	Atta	15	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st	reet, factory, office		28f. Location (S		er or Rural Route Number,	
Ö	afor Safte M Dii	Certification:		January, Sto.	1-677797				/		
	splt nara		29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge, deal	th occurred at the tir	me, date and plac	e, and due to the	cause(s) and mar	nner as stated.	
	To the Hospital or Attandl within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Medicai	(Check only 2 Medical Exami one)	ner: On the basis of e and manner state	examination and/or in	nvestigation, in my o	pinion, death occ	urred at the time,	date and place, a	and due to the cause(s)	
	ithin o th	₹	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)	
ì	F ≯ F 8		1 chino	mon	MO	10.	1854	2	05/3	/	
•			CN. 4 L	. 80			0 34		001.0	0 000	
	2		30. Name and address of person who co	ompleted cause of dea							
	25		Healther	LOKEVI		Medical	Center D	r., Rock	ville, M	D. 20850	
	Sta		31. Date filed (Month, Day, Year)		's Signature	de					
	Regist	rar	JON A T SAA	Jones .	JU JUJOS						

			1 ≝ For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	irtment of <i>tificate o</i>		nd Mental H	ygiene Reg. No.	2005	1990
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of I	Death Day	Year	3. Time of Death
	/Medi		Naomi Lo		sher			May 2	8, 200		1:30A M
	Examir	er	4a. Facility Name (If not institution, give Holy Cross Rehab		na		, or Location of			County of Death	
			5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Yes	nsville			ntgomer	
	Funeral Director		217-44-5757	м 2 Д F	93 Yrs.	Months Day		Min. (Month,	Day, Year) 191	9. Birth Cou Wash	place (State or Foreign ntry) ington, DC
	land Sw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Many f sh	to	Maryland Montgom	arv	Silver	Spring					1 Yes 2 □ No
	r 28a	Director	10e. Street and Number		BIIVEI	10f. Zip Code			10a, Citiz	zen of What Cou	
	h with	al D	15115 Interlach	en Drive	#701	20	906				s of Americ
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any follow goal for the months and the motified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 N If Yes, Give	0	Vas Decedent or Yes, specify Cu □ Yes 2X N		n? (Specify Yes or N Puerto Rican, etc.)	No- 1	4. Race - Ameri Black, White,	can Indian,
21215-0036	tural	ed b	15. Decedent's Edu	Year or Dates:	163 Deced	ent's Usual Occ	u pation				
15	n na	Completed	(Specify only highest grad	e completed)	(Give)	kind of work don OO NOT use reti	e durina most o	of working	16b. Kin	nd of Business/In	dustry
212	yiene.	шо	Elementary/Secondary (0-12)	College (1-4or 5- 5+	F)	inistra			Fede	ral Gove	ernment
פ	al Hygotha	Be C	17. Father's Name (First, Middle, Last)		'		18. Mother's	Name (First, Midd			
/lai	uid b Wents rrkad rica	To E	Jacob Love				Est	her Seide	rman		
Maryland	2 sho and Is ma		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	Address (Stree	et and Number	or Rural Route Num	ber, City or	Town, State, Zip	Code)
≥ ~	and ealth m 27		<u> Carl Love - Nepher</u>	J	1328	Church	Hill Dr	ive, Balt	imore	, MD 212	208
Ore	Fita H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Dispos cemetery, crem	ition (Name of	lace)	Date		ation - City or To	
<u>=</u>	E Pag tmen tant: jury		' 4 ☐ Donation 5 ☐ Other (Specify)		Mt. Leban			05/29/05		lphi, Ma	aryland
Baltimore,	permit Depar Impor any in		21. Signature of Euneral Service Licens	K	Edv 100	Name and Add Vard Sag	ress of Facility gel Fune gri 11e Pr	eral Direc ike, Rock	ction,	Inc.	852
			23a. Part . Enter the disease, or compl shock, or heart failure. List only or	cations that caused t	the death. Do not ente	r the mode of dy	ying, such as ca	rdiac or respiratory	arrest,	<u> </u>	Approximate Interval Between
	Firysician		Immediate Cause (Final disease or condition		ve Heart Fa					2	Onset and Death
	/Medical		resulting in death)		consequence of):	*IIule				3	Weeks
	Examiner	L	Sequentially list conditions,	Acute My	cardial I	farctio	on.			3	Weeks
	ed sit	Examiner	Sequentially list conditions, if any leading to immunicate cause. Enter Underlying Cause (Disease or injury	Due to for as a	consaction of						
_	xecui and	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
8760,	icate be executed physician and the burial-transit	dical									
687		edic								-	
Box	death certifi e attending p d for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o	f pregnancy				23	3d. Date of delive	IN.
	0 0 0	icla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 4 Pregnant at ti		Ectopic pregnan Other (s <i>pecify</i>) _.	су				Day Year
о. О	at the de by the a stached	hys	9 🗆 Unknown ²	9∐ Unknown							
	law requires that the as been signed by th 2 should be detache	by F	Part II. Other significant conditions cor	tributing to death but	not resulting in the un	derlying cause g	iven in Part I.	23e. Did	tobacco use	e contribute to th	e cause of death?
ecords,	w requires been sign should be	ted						_ 1 _	Yes 2 🔀	No 3 ☐ Prob	ably 4 Unknown
e C	law las be	Completed						24a. Wa:		24b. Were autor	osy findings available inpletion of cause of
<u> </u>	The tave cate has page 2.9	Con							ormed?	death?	
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	a a sibali				Death (Check only			
ō	Phys this al dii	2	1 ▼ Yes 2 No 27. Manner of Death	ospital: 1 Inpatient		3U DOX		ng Home 5 Res)
	ling After fune	u l l	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		ork?	28d. Describe	how injury	occurred	
DIVISION	or Attanding after death. Director: After in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injur	v . At home farm etro]Yes 2 □No	Opt Location	(C11	Alomboo	
<u>≥</u>	after death after death Director: d in by the	ertification:	4 Homicide determined	building, etc.	y · At home, farm, stree (Specify)	actory, office		City or To	wn, State)	Number or Rurai	Houte Number,
	To tha Hospital o within 24 hours af To tha Funaral D completely filled in	ledical C	29a. Certifier 1½ Certifying Phys (Check only one)	er. On the basis of e	my knowledge, death xamination and/or inve	occurred at the t	time, date and p opinion, death o	lace, and due to the	cause(s) ar	nd manner as sta	ated. the cause(s)
	o tha o tha omple	Med	29b. Signatus and title of certifier	and manner state	u.		se number	T		signed (Month, L	
			1/arro h	Hours	of new						
	12	-	30. Name and address of person who co	moleted douse of door	th (Item 222) 77:00 5		D12121		May 2	28, 2005	
		Ì	George Sengstack, 1				heaton	MD 2090	6		
	Stat		31. Date filed (Month, Day, Year)	M. Registrar'	s Signature		caton,	гш Z090	U		
	Registra		JUN 0 1 200°	Real	H. Consu	53					

			_	State of Ma	rvlan	d / Departi						Loo		
		1	For State Registrer		,	•	icate of				Reg. No)	19991
			Decedent's Name (First, Middle, Las	t)		- //	1/	- 11/		Date of De	aath Da	y Ye	ar -	3. Time of Death
	siciar edica	_	LOUISE			FU110	R - Ve	EAZEY	A	MAY	24			2005 PM
	mine	_	la. Facility Name (If not institution, give	street and number)	٠.	46	. City, Town, o	r Location of I	Death	į.	4c.	County of D		
			The Johns Hope 5. Social Security Number 6. S.	CINS HOS	HT C	last birthday)	Under 1 Year	ncine If Under 24	Hrs. 8	Date of Bi	rth	Balt		
Fune Direct		1	222-26-3166	C 14 a X c	52		onths Days		Min	Date of Bi (Month, Di -10-1	ay, Year) 942	3.1	Country	DE.
D D		- 1	Usual Residence of Decedent		10- 01	T								
larylar show			10a. State 10b. County	_		y, Town or Location	on						100	I. Inside City Limits 1 ☐ Yes 2 ☑ No
the M			De. Sussex			Laurel	Of. Zip Code				10a, Cit	izen of What	Countr	
If yiellid A I A I D-0030 should be filed within 72 hours after deeth with the Maryland of Mental Hygiene, marked other than "natural", or items 23a or 28a-1 show matic event the Moddel Energy and per rectified at manife over the Moddel Energy and per rectified at		5	166 Lakeside Driv	7e			199	956			US			
deeth		Jer	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U	.S. 13. Was	Decedent of H	lispanic Origin	n? (Specify	Yes or No	0-	14. Race - A Black, W		
after or fte	ļ	2	1 Never Married 2 Married	1 ☐ Yes 2X☐ No If Yes, Give	0		Yes 2∑XNo	Specify:		, 5.5.,		Specify:		
hours :	3	o no	3 Widowed 4 Divorced	Year or Dates:		16a. Decedent	s Henri Osono	ention			165 K	ind of Busine	Whi	
hin 72		Completed	(Specify only highest gra	de completed)	`	(Give kind	of work done of NOT use retired	durina most o	of working		160. K	ind or busine	SSINUU	stry
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at Hyy			17. Father's Name (First, Middle, Last)					18. Mother's						
y id 110 outd be fill Mental Hy larked oth	ļ		Marvin E. St					Mildr						
MET d 2 sh th and th and 7 ls m traum			19a. Informant's Name/Relationship (7			19b. Mailing A	,							ode)
Tand 27 Item 2			John R. Veazey, I	lusband	20b. P	lace of Dispositio	akeside		Date	irer,		cation - City		n, State
ages ant of it: If it			1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			emetery, cremato Fellows			-20-05			urel,		
DEMILITION 19, INICITY INICITY A TELESTOCOSO permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event. The Mudical Engine or interest to requise the rediffer a	ej .	-	21. Signature of Funeral Service Licen		ouu	22. Na	me and Addre	ss of Facility			La	urer,	De.	
	ouce		1 Cymples				ort Fur O West				199	56		
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	cations that caused tone cause on each line	the deatl	h. Do not enter th	e mode of dyin	ng, such as ca	rdiac or re	spiratory a	rrest,		l lr	pproximate Iterval Between Inset and Death
Physicia			Immediate Cause (Final disease or condition resulting in death)	a IdiopA	thic	· Yulm	ONARY	Fibi	R0515				1	5 yrs
/Medic Examin			resulting in death)	Due to (or as a	conseq	uence of):	0							1
	1	<u>ע</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseq	uence of):								
uted	1.0	Cyaninine	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
exectan an an an an an an an an an an an an a	3	ĽŽ	resulting in death) Last	Due to (or as a	conseq	uence of):								
OI VILGI DECOLUSY, T.O. DOX 00 (00), Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burnal-transit	icolt		(d									-	
Certification of the second of	MA	_	IF FEMALE:	23c. If ves. outcome of	f pregna	incv						32d Date of	dolivon	
eath c atten	100	2	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	Feta	Ideath 3 Ect	opic pregnancy ner (specify)	,			•	23d. Date of o Month	D	ay Year
the d	1000	2	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown										
s tha gned I	0	y l	Part II. Other significant conditions of	ontributing to death bu	not res	ulting in the under	lying cause giv	en in Part I.		23e. Did 1	tobacco u			cause of death?
w requires (been signer should be	200	ם ב	Theumonia	0 1 1:					_	1 🗆	Yes 2	<u>U</u> √0 3□	Probab	ly 4 □Unknown
taw r nas be	Poteicano	2	Pulmonary	Embolisy.	N					24a. Was	psy	24b. Were prior t death	o comp	findings available letion of cause of
i: The icate i	, ,					·				1 Yes	2 No		es 2	I No
VILCII Biclan: T certifical	a	٥	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 (Vinpatien	• 0 🗆	ER/Outpatient 3	Oth	er: Dece of				5 □Other (S		
ding Physician: The lav h	12	- -	27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time of	28c. Injun Worl	4 1140131				y occurred	pecity)	
tending leath. tor: Afte	1	2	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		rear)	Injury !		Yes 2 □ No						
rrAtte	in a contract of		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	y - At ho (Specify	ome, farm, street,	lactory, office			Location (City or To			Rural F	loute Number,
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune completely filled in by the fune.	100	200	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of and manner stat	examina	wledge, death occ tion and/or investi	gation, in my o	ne, date and p pinion, death	occurred a	t the time,	date and	place, and d	as state	ed. e cause(s)
ro the rothin rothin comple	1	2	29b. Signature and title of certifier				29c. Licens	e number			29d. Dat	e signed (Mo	nth, Da	y, Year)
,- 0	0		MI MA	M.	1)		RE	5-000	2		26	MAY	200	05
	9		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, Print	1)				_			
10			MONUN KAMRATNAM 31. Date liled (Month, Day, Year)	n 600 North	1 Wa	IFE STREET	BAltin	nore /	VIARYI	AND	2128	7		
	State istra		MAY 3 1	2005 SZ. Pristral	s signa	IFE STREET ture	de							

			For State Registrer	State of Mar	ryland			of He		nd Me	_	giene:	005	199	992
			Decedent's Name (First, Middle, La.	st)							2. Date of De Month		Year	3. Time o	of Death
	Physicia /Medic		Viola Annamay								36	10	05	112:3	5 M
	Examin	er	4a. Facility Name (If not institution, giv					mbe					County of De		
_			5. Social Security Number 6. S		(In vrs. la	ast birthday)	If Under		If Under 2		8. Date of Bir			irthplace (State	or Foreian
	Funeral Director			□M * 74	(111) 101 10	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da			Country)	or v oreign
	2	8	Usual Residence of Decedent			Ŧ					02-22	-123	1 MI	-	
	ehow	7	MD Allegar		-	Town or Loc lings	cation							10d. Inside 0	s 2 XNo
	28a-f	ecto	10e. Street and Number	11	raw.	111195	10f. Zip	Code				10g. Citiz	en of What (
3	Se or	Funeral Director	PO Box 99					557			į		USA	,	
	Geath ms 2	nera	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S	S. 13. V			anic Orig	in? (Spec	cify Yes or No Rican, etc.))- 1		nerican Indian,	
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3	urel',	d by	3 Widowed 4 □ Divorced	Year or Dates:							· · · · · · · · · · · · · · · · · · ·		d of Busines		
2	n "net	Completed	15. Decedent's Education (Specify only highest graduation)	de completed)		16a. Deced (Give i life. D	kind of wor OO NOT us	k done dui e retired)	ring most	of workin	g	TOD. KIII	d of busines	s/industry	
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<u>x</u>	Ment Ment arked	To	William Henry								May (
	reum		19a. Informant's Name/Relationship (-	,			Route Numb	•			
. ע	1 and Health em 27 ither tu		Barbara Snyder 20a. Method of Disposition	, Daughte:	20b. Pla	ace of Dispos	sition (Nan	ne of	1		Road,	Raw 20c. Loc	Lings ation - City o	or Town, State	1557
2	Pages nent of h int: If Ito		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			emetery, crem st_Lav				06-	14-05				
			21. Signature of Funeral Service Lice		1.	Car	danc	d Address	1	/ На	fer F	uner	al Se	rvice	P.A.
ŏ	permit. Departr Importe eny inji		(Join ()	Anna		1:	302	Nati	onal					21502	_ 0.1.0
			23a. Part r. Enter the disease, or com shock, or heart failure. List only	plications that oaused the	he death.	. Do not ente	r the mod	e of dying,	such as o	cardiac or	respiratory a	rrest,		Approxima Interval Be	tween
F	hysician		Immediate Cause (Final disease or condition	a Mas	sive	2_B	lee	ding	1					30 m	nutes_
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):	^	1							
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5	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):							1		
007	ate be nysicia he bu	icai		d							1/	-/-	W	W 1. ()	2 - 26
	entifica ling pl	Physician/Med	IF FEMALE:	23c. If yes, outcome of	f process						(1)	1	,	700610	,2005
	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal	death 3	Ectopic pr Other (sp					2	3d. Date of d Month	elivery Day	Year
5	y the	nysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9□ Unknown			101101 (0)								
L	s that ned b e deta	by PI	Part II. Other significant conditions	contributing to death but	not resu	ılting in the ur	derlying c	ause given	in Part I.		23e. Did t	tobacco us	se contribute	to the cause of	death?
corus,	w requires been sig	ed b			-						1 🗆	Yes 2	(No 3□1	Probably 4]Unknown
2	law requas been 2 should	Completed									24a. Was	an psy	prior to	autopsy findings completion of	available cause of
<u> </u>	The cate h page	Con									1 Yes	rmed? 2 ⊠ No	death? 1 ☐ Ye		
	Physicien: rthis certifica ral director, i	Be	25. Was case referred to medical examiner? released	Hospital:				Othon			(Check only o				
		: To	1 X Yes 2 No 27, Manner of Death	28a. Date of Injury		ER/Outpatien 28b. Time of		8c. Injury a	4 U Nur		8d. Describe			ecify)	
5	th. : After	ition	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	м		s 2 N						
<u> </u>	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined				et, factory	, office		2	8f. Location (Number or I	Rural Route Nur	mber,
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	o the	Me	29b. Signature and title of certifier	1		0.	290	License r	number			29d. Date	signed (Mo	nth, Day, Year)	
	2 - 0		1 Ash	- M	ν	Thyi	140	000	571	667		(0/10	105	
	6		30. Name and address of person who	completed cause of dea	ath (Item	23a) (Type,	Print)	1	7		1	1	1 1	, / 1	
	9		AShima S	aini MD	do Ciones	902		ton	Dr	l	Lu	mDe	Vand	Md	21502
	Sta Registr		31. Date filed (Month, Day, Year) JUN 15 2	37 Registrar	s Signal	A	de								

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** May A^{M} 28 2005 5:45 G. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RockVIIIe

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Feb. 17, 19 Rockville Shady Grove Adventist Hospital Montgomery 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 82 Yrs. Director 265-24-5127 1923 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified all once. 1 ☑ Yes 2 ☐ No Maryland Montgomery Gaithersburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8129 Langport Terrace 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Š 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 10 Care Giver Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Jones Lilv Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4724 Dauphine Blvd. Tallahassee, Fla. 32303 Clarence J. Downey / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 1, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 1 4 □ Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Puneral Service Licensee DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhage Pnysician Gastro in tertina disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0/17: Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 2 No 1 Yes Hospital or Attanding Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐mpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 / Homicide within 24 hours a 29a. Certifier (Check only one)

29b. Signature and title of certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ths 29c. License number 29d. Date signed (Month, Day, Year) D61817 May 28,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, MD 20850 S. Michael Gharacholou, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State 2005 Registrar

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		Dhuciai		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Dav	Year	3. Time of Death
	THE REAL PROPERTY.	Physici /Medio		Irene Emily	Gordon			May 24	, 2005		3:22P M
	1	Examin		4a. Facility Name (If not institution, give street and number)		•	or Location of Death		4c. County		
				Suburban Hospital		Bethe			Montg		
		Funeral		1 TH 2X15	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,)	(ear)	9. Birthpl	ace (State or Foreign try)
		Director		217-70-7046	51 Yrs.			JAN. 1,	1334	wasiii	ligton, DC
		land ow		10a. State 10b. County	10c. City, Town or Lo	cation				10	Od. Inside City Limits
		Mary Frah	호	Maryland Montgomery	Bet	thesda					1 XYes 2 No
		r 28g	<u>le</u>	10e. Street and Number		10f. Zip Code		100	. Citizen of V	Vhat Coun	try?
		th with	a D	5721 Grosvenor Lane		208	314	Uni	ted St	ates	of America
		deal deal	by Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Vas Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
	98	or It	y Fu	1	0	☐ Yes 2 XNo		, , , , , , , , , , , , , , , , , , , ,		Whit	
	8	hours urel',	d b	3 Widowed 4 Divorced Year or Dates:	1 10: 5:	Leade III I O					
	5	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	16a, Deced	lent's Usual Occup kind of work done OO NOT use retire	pation during most of work d)	ing 16	8b. Kind of Bu	siness/Ind	ustry
	12	within ene. than	m d	Elementary/Secondary (0-12) College (1-4or 5-	F) [ashier	- ,		Rest	urant	•
	d 2	filled Hygi Sther	ပိ	17. Father's Name (First, Middle, Last)	, , ,		18. Mother's Name	e (First, Middle, Ma			
	an	id be ental ked o	To Be	Nathan Gordon			He1e	en Sherma	n		
	ary	shou ind M ind M	-	19a. Informant's Name/Relationship (Type, Print) Socia	Lcal 19b. Mailin		and Number or Run				
	Σ	alth a		Elynne T. Bunnag - Worke	er 8881			805, Sil	ver Sp	ring,	MD 20910
	ore,	of He of He		20a. Method of Disposition	20b. Place of Dispos cemetery, crem	sition (Name of natory or other plac	ce)	Date 20	c. Location -	City or Tox	wn, State
	Ē	Page nent ant: If ury o		1 X Burial 2 □ Cremation 3 X Pemoval from State • 4 □ Donation 5 □ Other (Specify)	King David			05/31/05	Fal1	s Chu	rch, VA
1522	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "neturel", or Items 23e or 28e-f show any injury or other traumatic svent, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee			ess of Eacility Goldberg ville Pike				
15				23a. Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin.	the death. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arres	l,		Approximate Interval Between
4	1	Physician			c Arrest						Onset and Death
1	7	/Medical		resulting in death) Due to (or as a	consequence of):						
5		Examiner		Sequentially list conditions b. Congest	tive Heart	Failure					
7		p ti	Iner	cauch Enter I Inderlying	consequence of):	naion					
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(~	60,	ate be executed hysician and the burial-transit	cal E	200 10 (0. 00 0	ctive Sleep	Apnea					
	P.O. Box 68760,	phys phys s the		d							
Preclos	X 6	uires that the death certifica signed by the attending pt d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date	e of deliver	v
3	B	death a atter	clar	in the past 12 months?		Ectopic pregnancy Other (specify)	y 		Mor		Day Year
5	0	t the c by the achec	hys	9 ☐ Unknown 9☐ Unknown							
< F	S, P	s thai	by P	Part II. Other significent conditions contributing to death but			ven in Part I.	23e. Did toba	cco use contr	bute to the	a cause of death?
)	rd	equire en sig	edt	Insulin Dependant Diabetes	, Obesity,	<u> </u>		1 🗆 Yes	2🗓 No	3 Proba	ibly 4 □Unknown
a)	Vital Record	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed	Hypoventalation Syndrome,	Hypertensi	Lon,		24a. Was an autopsy performe	d? d	rior to com eath?	sy findings available apletion of cause of
ent	a	ificat or, pa		Down's Syndrome 25. Was case referred to medical			26 Place of Deat	1 Yes 2 (Check only one)	XNo 1	☐ Yes 2	2 No
>	>	Physicien: r this certific ral director,	To Be	examiner?	nt 2 ER/Outpatient	t 3□ DOA Oth		me 5 Residence	ce 6 □Othe	r (Specify))
(-+	of	g Ph ter th		27. Manner of Death 28a. Date of Injury	Year) 28b. Time of Injury	28c. Injur Wor		28d. Describe how			
	io	Mtendin death. ctor: Af y the fur	atlo	2 Accident investigation			Yes 2□No				
	Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inju building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,
	Q	itel o urs aff ral Di		~							
		To the Hospitel or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of and manner state and	examination and/or inv						
_		To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. Licens	se number	290	. Date signed	(Month, D	Pay, Year)
		8		I Try Michael	- A	D0053	691	Ma	ay 27,	2005	
		3		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, I						
				A.J. Reddy MD 6320 Demo	cracy Blvd	Bethe	sda, MD 2	0817			
		Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 2005	r's Signature	ASSI					
I		-									

			1 - For State Registrar	State of Mary	land / Depa			lental Hygi		5 19995
	Physic	ian	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
4	/Medi	cal	Apresentacao		Gallo			May 26,	2005	1:30 A M
	Exami	ner	4a. Facility Name (If not institution, give Manor Care	street and number)			or Location of Death		4c. County of I	
			5. Social Security Number 6. Se	7 500 (10	1	If Under 1 Year	Bethesda			gomery
	Funeral Director			M 2⊠F	yrs. last birthday) 91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 23)	,1914 9.	Birthplace (State or Foreign Country) Portugal
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-1 ehow ha Madical Examiner is wat by mylitled at		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Mar Filed	ģ	DC Not	ne	Washing	gton				1 X Yes 2 □ No
	or 28	lrec	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wha	t Country?
	23a	Completed by Funeral Director	4923 43rd Plac	ce, NW		2	0016		USA	
	ems ems	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I	dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - /	American Indian,
36	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 ♣ No If Yes, Give		1 Tes, specily Cub 1 □ Yes 2 □XNo		nican, etc.)		Vhite, etc.
ğ	ural',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		103 203410	эрвспу.		Specify: W	nite
<u>ν</u>	nat nat	lete	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give	lent's Usual Occup kind of work done	pation during most of worki d)	ing 16	6b. Kind of Busin	ess/Industry
2	withir sne.	g.	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>00 NOT</i> use <i>retire</i> nager	d)		TD.	1
7	Hygie ther int, II	ပိ	17. Father's Name (First, Middle, Last)		110		10 Matheda Nama	/First 140-140-140-140-140-140-140-140-140-140-		akery
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Marylan I filem 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	To Be	Joao Fernand				18. Mother's Name	Jesus		
, Mai	and 2 st ealth and n 27 Is n	13	19a. Informant's Name/Relationship (Ty John Gallorini/S	on	4923	43rd P1a	and Number or Rura ace, NW, V			
9	S S S S		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ P	emoval from State	 b. Place of Disposition cemetery, cren 	sition (Name of natory or other plac	ce)		c. Location - City	
Ē	ment tant:		`4 □Donation 5 □Other (Specify)			Heaven Ce	em. June	4,2005 s	ilver Sp	oring, MD.
ă	epart epart poor y in		21. Signature of Fune 1. Service Lo	99 ///	22	Name and Addre	ss of FacilityDeVo	1 Funera	1 Home	<u> </u>
	20299		LAM XX	Ill	2	222 Wisco	onsin Ave.	,NW.,Was	hington,	DC 20007
	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the die cause on each line. Chronic I Due to (or as a con-	Renal Fa:		ng, such as cardiac o	r respiratory arrest	t,	Approximate Interval Between Onset and Death
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	cuted	Examiner	Cause (Disease or injury that initiated events	C diffic	il colit	is				
Ď	an ar	EX	resulting in death) Last	Due to (or as a con-						
08/00,	ificate be executed g physician and as the burial-transit	edicai		Ischemic	changes	1eft foo	t			
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ב, א	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions con Dementia	tributing to death but not	resulting in the un	derlying cause give	en in Part I.			to the cause of death? Probably 4 Munknown
္ဌ	law require as been si 2 should b	jet						24a. Was an	24h Wara	autopsy findings available
		e Completed	25. Was case referred to medical					autopsy performed 1 ☐ Yes 2 🔀	d? prior	o completion of cause of
>	/sicie	OB	examiner?	ospital:	ER/Outpatient	aClass. Othe	26. Place of Death			
5	Attending Physicien: sr death. ector: After this certifica by the funeral director.	\vdash	27. Manner of Death 1 █ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year		28c. Injury Work		8d. Describe how i	e 6 Other (Sinjury occurred	oecify)
ה ה	tendi death. for: A the fu	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No			
5	tel or Attences after death	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ecify)	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or state)	Rural Route Number,
	Hospi 4 hour Funer ely fill	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or inve	occurred at the timestigation, in my op	e, date and place, a pinion, death occurre	nd due to the caus of at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
1	To the within 2 To the complet		29b. Signature and title of certifier	2/-10		29c. License		29d.	Date signed (Mo	nth, Day, Year)
	5) Cuti	VOW	a M	// D20	0274		May 2	26, 2005
•	_	1	30. Name and address of person who cor Kirti Vohra, MD,				la. MD oc	1817	_	
ı	Stat Registra		31. Date filed (Month, Day, Year) JUN 0 1 2005	32 Registrar's Sig			3 110 1 20	.011		

		1 - For State Registrar			ertificate of E		ental Hygier Reg. I	2000	1999
Physici /Medi		Decedent's Name (First, Middle, Last HATTIE	•	GARVIN				Day Year 29 2005	3. Time of Death 11:52P
Examir	ner	4a. Facility Name (If not institution, given PRINCE GEORGE'S F	IOSPITAL	(In yrs. last birthday	4b. City, Town, or CHEVERI			PRINCE G	EORGE'S
Funeral Director		264-16-4904 Usual Residence of Decedent	□M 25xF	86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea February	14 South	Carolina
28a-f show	ector	DC 10a. State 10b. County DC 10e. Street and Number		VASHIN	IGTON, DC		100	Citizen of What Cou	10d. Inside City Limi 1 X Yes 2 □ N
s 23a or	Funeral Director	4339 BOWEN ROAD S			20019		J	U.S.A.	
ene. than "natural", or Hems 23a or 28a-f show na Madical Examinat must be nutified at	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒ No		cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: BLA	
jiene. r than "natur ire Madical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8th		(Giv	edent's Usual Occupate kind of work done do DO NDT use retired)	tion uring most of workii	16b.	Kind of Business/In	dustry
evant,	To Be Co	17. Father's Name (First, Middle, Last) ISAIH GARBIN				18. Mother's Name	(First, Middle, Maid E GORDON		
lealth and Im 27 is m har traum		19a. Informant's Name/Relationship (19a. Name/Relationship)		6847	FOREST TE	ERRACE LA	NDOVER, MA	ARYLAND	20785
rtment of rtant: If i njury or		20a. Method of Disposition 1 Burial 2 Comment 3 Other (Specify 21. Signature of Europa Septice Licen)	RIVERDAL	ematory or other place E CREMATOR	Y 6/3/0	D5 RIV	ERDALE, MA	RYLAND
Depa Impo any I	de la	21. Signature of carreiral segretor Licent	500		2. Name and Address 7474 LANDO	•		IS FUNERAI MARYLAND	
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n signed by the uld be detached	by	Part II. Other significant conditions of Diabetes Mellitu		t not resulting in the	underlying cause giver	n in Part I.		use contribute to the	
ate has been si page 2 should	Completed	Breast Cancer					24a. Was an autopsy performed?	prior to co death?	psy findings availa npletion of cause 2⁄2 No
r death. actor: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	t 2 🔀 ER/Outpatie 28b. Time of Injury	of 28c Injury a	at 2	(Check only one) e 5 Residence 8d. Describe how inj		()
in Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, si (Specify)	reet, factory, office	2	8f. Location (Street a City or Town, Sta		l Route Number,
4 I G	edical	29a. Certifier 1 X Certifying Ph	ysician: To the best of iner: On the basis of e and manner state	examination and/or in	th occurred at the time envestigation, in my opin	, date and place, a nion, death occurre	nd due to the cause(d at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
	ž	29b. Signature and title of certifier	1 /100	4. /	29c. License	number	29d. D	ate signed (Month,	Day, Year)
within 2 To tha I		Michiella.	L. X/Iau	19 M.	224	435	Ma	y 31, 20	05

	1 - For State Registrar			ertificate	of D	eath		Reg. No.	105	190	9
	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of	
nysician Medical	Betty Gramby						May	ربده		5 1500	, N
iner	4a. Facility Name (If not institution, giv	e street and number)		4b. City, T	Town, or L	ocation of Death	7	4c. Cou	nty of Deat	1	
	Peninsula Legia	nal Nedic	al Cente	· 5	ali-	shurd		Wi	ani		
	5. Social Security Number 6.5	ex 7. Age	(In yrs. last birtho	Months	1 Year Days	Il Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birtl	nplace (State o untry), J1n1a	r Foreig
	215-14-3898	UM 2UF 91	Yr	5.			January		Vir	gińia	
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location						10d. Inside Ci	y Limit
ō			•							1 ☐ Yes	
Director	Maryland Wicomico 10e. Street and Number		Salisb	10f. Zip (Code			10g. Citizen	of What Co	21	
ā										,	
Funerai	306 Martin Street 11. Marital Status	12. Was Decedent 8	Ever in U.S.		804 ent of His	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No	USA - 14. F	ace - Ame	ican Indian,	
ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	io	_			Rican, etc.)		lack, White	-	
δ	3 [™] Widowed 4 □ Divorced	If Yes, Give 22 Year or Dates:		1 ☐ Yes 2	°L No	Specify:		Spe	cify: Bla	CK	
ted	15. Decedent's E	ducation	16a. D	ecedent's Usual	Occupat	ion	ina	16b. Kind of	Business/l	ndustry	
ple	(Specify only highest gra	College (1-4or 5	+)		e retired)	iring most of work	,,,g	Domest	ia		
Completed	4th			Laborer				Dulest.			
Be	17. Father's Name (First, Middle, Last)			1	18. Mother's Name	(First, Middle,	Maiden Sum	ame)		
10	Robert Smith					Mary Soc	ott				
	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address	(Street an	nd Number or Run	al Route Numbe	er, City or Tov	m, State, Z	ip Code)	
	Mary Lee Gramby/Daught	er	P.O.	Box 96 -	Pitts	sville, Mar	yland 21	850			
	20a. Method of Disposition 1 🖰 Burial 2 🗆 Cremation 3	Damaual from State	20b. Place of Di cemetery,	sposition (Name crematory or oth	e of her place,)	Date	20c. Locatio	n - City or	own, State	
	'4 □Donation 5 □Other (Specif		St. Jame	s Ch. Cem	etery	May 3	1, 2005	Westove:	, Mary	<i>r</i> land	
	21. Signature of Funeral Service Licer	1588		22. Name and	Address	of Facility	1213 Jes	rsev Roa	d - Sa	lisbury,	MD
	Fosesta E	. Valle	4	Jolley M	emori	al Chapel		21801			
	23a. Part1. Enter the disease, or me shock, or heart failure. List only	plication that caused	e death. Do not	enter the mode	of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Bety) veen
	Immediate Cause (Final			, 1 t	-, 17	11/15-				Onset and I	leath
	disease or condition resulting in death)	Due to (or as a	a consequence of):	10 1	47 /	G C (1000	7>
		ASPIVE	341011	PHELI	111	DUIS				304	41
Jer	if any, leading to immediate	Due to (or as a	consequence of)		001						
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
ŭ	resulting in death) Last	Due to (or as a	a consequence of):								
cal		d									
Med	IF FEMALE:	-			<u> </u>						
Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth	2 Fetal death	3 □Ectopic pre					Date of deli-	,	'ear
sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown	time of death	5 Other (spe	icify)			'	- un sal l	-uy 1	-wal
Phy	9 Unknown					to note:	60. 5		and the second	the economic of the	nath?
by	Part II. Other significant conditions of AG CU	-	it not resulting in th	e underlying ca	use given	ın Part I.				the cause of dibably 4	-
Completed	179 60%	>					1	res 2□No	3 L Pro	oauly 4 [IKNOW
pie							24a. Was autop		. Were aut	opsy findings a	vailab
Our							perfo 1 Yes	rmed?	death?	210 No	
Be C	25. Was case referred to medical examiner?					26. Place of Death					
일	examiner?	Hospital: Inpatier		tient 3 DOA	Other	4 Nursing Ho	me 5 Resid	dence 6 🗆 C	ther (Spec	ify)	
	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Tim Year) Inju	e of 28	lc. Injury a Work?		28d. Describe I				
atic	2 Accident investigation	n		М		es 2 🗆 No					
Certification;	3 Suicide 6 Could not b	28e. Place of Inju	ry - At home, farm :. (Specify)	street, factory.	office		28f. Location (5 City or Tox		nber or Ru	al Route Numi	er,
Cer											
	29a. Certifier 1 Certifying Pt	ysician: To the best on iner: On the basis of	of my knowledge, d	eath occurred a	t the time	e, date and place,	and due to the	cause(s) and	nanner as	stated.	
Medical	one)	and manner sta	ted.				ou at the thine,	uate and plac	e, and due	to the cause(s)	
Σ	29b. Signature and title of certifier		٠.	-	License			29d. Date sign	ned (Month	Day, Year)	
	MALUL (or ulla	· m	_	day of the same of	2014		2/23	-105		
	30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	pe, Print)			_ , ,	n 1.			
1	30. Name and address of person who MAMES H (A) 31. Date filed (Month, Day, Year) MAY 3 1	10000V	9 116	WITH	ova	1 5/- 5	04 B	SAIRS	1340	4 91/3	

			State of Maryland / Department of Health and Me	ntal Hygier	ne 2001	10000
			Registrar Certificate of Death	Reg. I	16. UUU	3. Time of Death
	Physici	an	BICII	Month E	Day Year	2/2/0M
1	/Medio Examin		4a. Facility/Name (If not institution, give street and number) 4b. City, Town, or Location of Death	May 3	c. County of Deatl	1 LI LOP
	Examin	ei	Coastal Hospice At the Lake Salisbury		(1).0	pm:co
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign
	Director		229 - 96 - 0044 DAM 2LIF 42 Yrs.	7-27-	62	"VA
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary	tor	MD WICOMICO SALISBURY			1 Yes 2 □ No
	th the	Director	10e. Street and Number 10f. Zip Code	10g. 0	Citizen of What Co	untry?
	ath w		813-SemINOLE BLVD 21801		US	A
	Hems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Never Married 2 ☐ Married 1 ☑Never Married 2 ☐ Married 1 ☑Never Married 2 ☐ Married	y Yes or No- can, etc.)	14. Race - Amei Black, White	
936	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Examinat I.s. rodilised at	by	1 Never Married 2 Married 1 Never S 2 No 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: HRINN 1 Yes 2 No Specify:		Specify: B	LACK
21215-0036	be filed within 72 hours ital Hygiene. Id other than "natural", event, the Medical Exp	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b.	Kind of Business/I	ndustry
21	Athin han "	mpie	Elementary/Secondary (0·12) College (1·4or 5+)	6	m	01-11-5
	filed with Hygiene. other thai		17. Father's Name (First, Middle, Last) 18. Mother's Name (F		ELF-EA	VLOJED
ano	should be filed with nd Mental Hygiene marked other tha matic event, Ins.	To Be	JESSIE L. ANDERSON CARRIE	1- C	\	
Maryland		-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R	Route Number, City	or Town, State, Z	ip Code)
_	1 and 2 Health a tem 27 ls		PEGGY A. GIDDENS - SISTER POLBOX 143 NELSONIA RO	NELSOI	ULA, VA S	13414
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20c.	Location - City or I	Town, State
Ë	permit. Pages Department of Importent: If It any injury or c		4 Donation 5 Other (Specify) (REMATERY OF DELMANA 6/3		ELMAR	DE
Bal	permit. Pag Department Importent: I any injury o	l la	21. Signature of Funeral Service Licensee		nITH F	H
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	SALISS espiratory arrest,	ury, mo	2 80 Approximate Interval Between
	Physician		shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition Tempure Tempure Tempure	Syndro	me	Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	- jung	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	114-2115
	Examiner		Sequentially list conditions, b.	1.10.2		
	led sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	al-tra	Exar	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d			
9	rtifica ng ph as th	Medi	IF FEMALE:			
Вох	death certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliver Month	very Day Year
0	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)			
Δ.	res that tigned by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Records,	w requires been sigr should be	ed by		1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown
ဝ၁	e taw re has bee je 2 sho	Completed		24a. Was an autopsy		opsy findings available
		Com		performed? 1 ☐ Yes 2 ☐ N	death?	212No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: 4 Testion 2			
of	hys his II dii	To	1 Anpatient 2 Envoutpatient 3 DOA 4 Nursing Home	5 Residence 1. Describe how in		ify)
On	th. : After s funera	tion	SNatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	er dearector	Certification;	a Cincinnation of Cincinnation	Location (Street a	and Number or Rui	ral Route Number,
D	itel or rel Di					
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funera	Medicai	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner/staled.	I due to the cause(at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	o the o the	Me	28th. Signal yre and time of contribir 29c. License number		ate signed (Month	Day, Year)
	- > - 0		DC264, MD 026278		6-1-0	75
	28		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2 (1./	N 21862
			DAVID E COLALL, M) CONSTAL HERPILE POLOGY 173	1) 10/	166) h	10 7/80=
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OHVID C. COLLELL, MD. CONSTAL FEEFICE: POBCX 173 31. Date filed (Month, Day, Year) JUN 0 2 2005 Shake & Sparker JUN 0 2 2005		_	
		1				

			State of Maryland /	Depa	ırtment	of H	ealth a		lental Hyg	/	The state of the s	9999		
			1 - State Registrar Certificate of Death Reg. No. 2 U J 1. Decedent's Name (First, Middle, Last) 2. Date of Death									3. Time of Death		
	Physicia /Medic Examin								Month	Day	Year 2005	M		
			Joseph John Hamm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						May	9:20 a				
		eı	3245 Main Street		Ma	anch	estei	r		Carroll				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b.		If Under 1		If Under:		8. Date of Birth (Month, Day April			place (State or Foreign		
-	Director		220 02 7001	Yrs.	10,011110	Jayo			April	5 1983	<u> </u>	" MD		
	D	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Lo	cation					-	10d. Inside City Limits			
	dary!	ō										1 7 Yes 2 □ No		
	a within 72 hours after death with the Maryland sien. Jen	Director	MD Carroll Manchester 10e. Street and Number 10f. Zip Code							f What Cou	ntry?			
		i Die	3245 Main Street				L102			U	SA			
		ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decede	ent of His	spanic Ori	gin? (Spi n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.			
Baltimore, Maryland 21215-0036		by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:						Spec	ec <i>ify:</i> White			
	turel',		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16i							16b. Kind of	6b. Kind of Business/Industry			
	in 72 i "nat	olete	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)						king					
	d within piene. r then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Disabled							N/A				
	in the	Bec	17. Father's Name (First, Middle, Last)						First, Middle,		ame)			
	12 should h and Mer 7 is marke traumatic	10 10	Arvil Glen Hamm, Jr						ra Gamb					
			19a. Informant's Name/Relationship (Type, Print) Barbara Hamm/mother	9b. Mailir 324	ng Address (15 Mai	(Street a n St	reet	er or Run Ma	a <i>i Route Numbe</i> ncheste	r, City or Tou r, MD	n, State, Zi 2110			
	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place cemet	of Dispo	sition (Name	e of her place	9)	5/28	72005	20c. Location	n - City or T	own, State		
	permit. Pages Department of t Importent: If its any injury or o once.	1			en Mem			rden	s	Fin	ksbur	g, MD		
Balti			21. Signature of Juneral Service Licensee	P	Name and	Fun	eral	Home	e and Ch	napel,	P.A.	21157		
	Ale be executed transit at the burder francial transit at the		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Batween											
760,			shock, or heart failure. List only one cause on earn line. Immediate Cause (Final disease or condition											
			resulting in death) a. Due to (or as a consequence of):											
			Sequentially list conditions, b. The Third Conditions, b. The Sequentially list conditions, b. The Sequentially list conditions, b. The Sequentially list conditions, b. The Sequentially list conditions, b. The Sequentially list conditions, b. The Sequentially list conditions, b. The Sequentially list conditions, b. The Sequential list conditions is the Sequential list conditions, b. The Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions is the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditions in the Sequential list conditio											
		Examiner	Sequentially list conditions, and seating a formal accause. Enter Underlying Cause (Disease or injury that initiated events	a oi):	*	1.								
		хап	that initiated events resulting in death) Last Due to (or as a consequence of):											
		calE												
68	tificati g phy as the					`	-							
Box	leath certificate attending phy ifor use as the	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ €ctopic pregnancy								23d. Date of delivery Month Day Year			
	e death	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								(North)			
P.0	that the de led by the a detached i	Phy							23e. Did to	Did tobacco use contribute to the cause of death?				
	iician: The law requires certificate has been sign rector, page 2 should be	l by	Tatti, out significant continuous graduation and a second continuous graduation and a						1 🗆 1	1 Yes 2 No 3 Probably 4 Unknow				
Ö		Completed				_			24a. Was	an 2	b. Were aut	opsy findings available		
Records,		m								rmed?	death?	ompletion of cause of		
Vital		ပို									No 1 Yes 2 No			
Ξ		ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatie	nt 3 DO/	A Oth	er: 4: □ Ni	ursing Ho	ome 5 Nesid	nesidence 6 □Other (Specify)				
υot	ding Phys n. After this funeral di	l ii	(Month Day Year)	. Time o	of 28	8c. Injun Wor			28d. Describe I	now injury occ	curred			
Division	Hospitel or Attend 4 hours after death Funerel Director: tely filled in by the	atic	1 Alatural 5 Pending (North, Day Feat) Injury Vol.1: 2 Accident Injury M 1 Yes 2 No											
		Certification:	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							Location (Street and Number or Rural Route Number, City or Town, State)				
		S	29a. Certifier 1 Certifying Physician: To the best of my knowled	lae dea	th occurred a	at the tin	ne, date a	nd place.	and due to the	cause(s) and	manner as	stated.		
		edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within 2 To the comple	Me	29b. Signature and title of certification		29c.	Licens	e number	0		29d. Date sig	ned (Month	. Day, Year)		
			Day	3	2	$\mathcal{D}_{\mathcal{S}}$	848			5/	25/0	5		
	8		30. Name and address of person who completed cause of death (Item 23a	а) (Туре	Srint)	0	. 1	5	11	\	,	> 71.71		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature						> Ha	MESTO	3,4	19 21014					
	St Regist	ate trar	MAY 2 7 2005	K	Areal .									
			7-5-0-1		1									

			1 - For State Registrar	State of Maryla		artment <i>tificate</i>			ind M	Re	g. No.	0.0		
1. Decedent's Name (First, Middle, Last) Physician To 1							1			2. Date of Death Month May 31		Year	3. Time of Death	
	/Medic			Elsie Jane Hennessy						May 31	, 2005		9:00 A M	
	Examin		4a. Facility Name (If not institution, give					or Location of Death			4c. County of Dea		1.	
			26901 Yowaiski M		to a bink to b			If Under 2		0.0-1	St.			
	Funeral Director		212-16-411/	7. Age (In yr.	90 Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Aug. 10,			place (State or Foreign ntry) ginia	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be collided at once.	rector	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. Inside City Limits	
			MD St. Mary	la Ma	chanics								1 ☐ Yes 2 🗽 No	
			10e. Street and Number	S THE	CHAILLES	10f. Zip				10	g. Citizen of \	What Cou	ntry?	
	3a or	<u></u>	26901 Yowaiski Ma	ill Road		20	659				U. S	. A.		
	death	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Nas Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	e - Ameri	can Indian,	
9	or its	F	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ☒ No Specify:			rioan, etc.)		Black, White, etc. Specify:			
21215-0036	ural'.	To Be Completed by Funeral Director	3 Widowed 4 Divorced Year or Dates:			16a. Decedent's Usual Occupation						White		
2	"natu		15. Decedent's Edu (Specify only highest grad	cation a <i>completed)</i>	(Give	ient's Usual <i>kind of worl</i> DO NOT use	k done di	urina most	of worki		6b. Kind of B	usiness/In	dustry	
7	withir ane. than		Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		<i>- 1001100)</i>				At H	Om o		
0	filed Hygie Sther I		17. Father's Name (First, Middle, Last)		Homen	laker		18. Mothe	r's Name	(First, Middle, M.				
an	should be ind Mental I		Benjamin Dodson					Sara	a E1:	len				
Maryland	shou and M s mar umat		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Number,	City or Town,	State, Zip	Code)	
altimore, M	and 2		Ruby Faulds / Dau	<u> </u>				Mil:	1 Rd	. Mechan	icsvil	1e, 1	MD 20659	
	of He of He fiter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F		Place of Dispo cemetery, cren	sition (Nam- natory or oth	e of her place	9)	D	ate 2	0c. Location -	City or To	own, State	
Ĕ	Pages ment of i ant: If it		`4 □ Donation 5 □ Other (Specify)							1,2005 C				
Ball	permit. Depart import any in		21. Signature of Funeral Service License	(L.Hme.,P.A. MD 20622	
Division of Vital Records, P.O. Box 68760,	whysician and hysician and the burial-transit	Physician/Medical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	ence of):	i fem	ali tu	ve M	d 1°C	S A	1.		Approximate Interval Between Onset and Death	
	death certific e attending p id for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)									23d. Date of delivery Month Day Year		
	uires that signed t d be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown				
	aw require as been sig 2 should b	Certification; To Be Completed								24a. Was an autopsy	24b. \	Were auto	opsy findings available impletion of cause of	
	ine law ate has page 2 s									performe	ed? c	leath?	2 No	
	ysician: The is certificate hidirector, page		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho 27. Manner of D ath 1 Namer of D ath						of Death	ath (Check only one)				
	ding Physic n. After this co funeral dire								2	me 5 X Residence 6 ⊡Other (Specify) 28d. Describe how injury occurred				
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, stre	M eet, factory,		es 2□1	-	28f. Location (Stre City or Town,	Street and Number or Rural Route Number, vn, State)			
	Hospital or A		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hospital within 24 hours a To the Funeral I completely filled	edical												
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number					290	29d. Date signed (Month, Day, Year)					
			D 47066						0	5-31.05				
1	0 5		30. Name and address of person who co				-d+0-	M CTV	2277	and 2065	0			
1	الرارا	10	A. D. Shah, M.D. 31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature			W11 , 1 ¹ 1	aryl	anu 2003				
	Sta Registr		JUN 0 1 2		K A	perte								